

VP 5 (4)  
1 2 61

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>432 E.Church Street</b>		d. STREET ADDRESS <b>432 E/Church St.</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print)		First <b>ELVA</b> Middle <b>REBECCA</b> Last <b>ADKINS</b>		<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>23</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>June 2, 1888</b>		<b>9. AGE (In years last birthday)</b> <b>73</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>9</b> Days <b>21</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House work at Home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Salisbury, Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>		<b>13. FATHER'S NAME</b> <b>Elihu William White</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Downing</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> 		<b>17. INFORMANT</b> <b>Mrs. Jean Smith (Daughter)</b> Address <b>310 Middle Blvd. Salisbury, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>4-22-62</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>" Insufficiency "</b> DUE TO (c)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>N/A</b> 19 p.m.		<b>20d. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
<b>20f. (City or town)</b> <b>N/A</b>		<b>(County)</b> 		<b>(State)</b> 	
<b>21. I certify that (1) (this hospital) attended the deceased from</b> <b>Mar 1, 1962</b> <b>to</b> <b>Mar 26, 1962</b> <b>that (1) (we) last saw the deceased alive on</b> <b>Mar 1, 1962</b> <b>and that death occurred at</b> <b>9:30 P.M.</b> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>W. B. Smith</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>March 26 / 1962</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. William B. Smith</b>		<b>22d. ADDRESS</b> <b>Salisbury, Maryland</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Mar. 26, 1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>	
<b>23d. LOCATION (City, town or county)</b> <b>Salisbury, Maryland</b>		<b>(State)</b> 			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>		<b>ADDRESS</b> <b>SALISBURY, MARYLAND</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 27 '62</b>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Thomas</b>	

03230

03230

(M)

(1)

Handwritten notes and stamps, including "03230" and "M".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03881

03877

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ocean City Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b> d. STREET ADDRESS <b>Ocean City Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN EDWARD ADKINS</b>		4. DATE OF DEATH <b>MARCH 19th 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee-Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR Months <b>9</b> Days <b>17</b> IF UNDER 24 HRS. Hours <b>17</b> Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Whaylesville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Edward Bowen Adkins</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Brittingham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>199X</b>	
17. INFORMANT <b>Mrs. Mame S. Adkins (Wife)</b>		Address <b>Ocean City Road Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b> <b>199X</b> DUE TO <b>Site of origin unknown</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/19/62</b> to <b>3/19/62</b> that (I) (we) last saw the deceased alive on <b>3/19/62</b> and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Earl M. Beardsley</b> M.D.		22b. DATE SIGNED <b>March 21, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 21, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) <b>Salisbury, Maryland</b> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 22 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



12821

DATE OF DEATH

08877

Location

(Inmate) Salisbury

Salisbury (Inmate)

Green City Road

Green City Road

John

John

White

White

British Empire-British

British Empire-British

Edward Bowen Adams

Edward Bowen Adams

Edward Bowen Adams

NA

NA

0:00:11

0:00:11

Dr. J. H. Adams

Dr. J. H. Adams

Dr. J. H. Adams

Dr. J. H. Adams

Dr. J. H. Adams

Dr. J. H. Adams



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03882

03878

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Parsonsburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsburg (Rural)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D.# Mt Hermon Road</b>				d. STREET ADDRESS <b>R.D.# 1 (Mt Hermon Rd)</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SALLY ANNIE ADKINS</b>				4. DATE OF DEATH Month Day Year <b>MARCH 26th 19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Dec. 26, 1880</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico Co., Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>John E. Freeny</b>				14. MOTHER'S MAIDEN NAME <b>Sally E. Morris</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>N/A</b>			
17. INFORMANT <b>Mrs. Margie A. Holloway (Daughter) R.D.# 1 Parsonsburg, Maryland</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoarthritis of spine - bed ridden 3 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>				20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>N/A 19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>			
20f. (City or town) (County) (State) <b>N/A</b>				21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>3-26</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3-25</b> , 19 <b>62</b> , and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank Lewis</b>				22b. DATE SIGNED <b>March 29 / 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Frank R. Lewis</b>				22d. ADDRESS <b>Willards, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Mar. 29, 1962</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Grove Cemetery-R.D.# Parsonsburg, Maryland</b>				23d. LOCATION (City, town or county) (State) <b>Parsonsburg, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				25a. REC'D BY REGISTRAR <b>APR 2 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

M

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Wanted

(An-1) - Unsubstantiated

H.D. Mc Hanson, New

Parasitology (Bacter)

T. J. (Mc Hanson, New)

Wanted

Wanted

Wanted

Wanted

Wanted

Wanted

John E. Gandy

Wanted

Wanted

Wanted

Wanted

Wanted

Wanted

Wanted

Wanted

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03883

03879

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAFORD</u> <u>46X-3</u> d. STREET ADDRESS <u>413 HIGH STREET</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>BATHANA LOWE ALLEN</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 24, 1962</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JAN. 14, 1879</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>DORCHESTER, MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>THOMAS A. LOWE</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY ANNE LOWE</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>DR. BENSON ALLEN</u> Address <u>413 HIGH STREET SEAFORD, DELAWARE</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lymphocytic Leukemia</u> 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>204-3</u> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3-12, 1962</u> <b>to</b> <u>3-24, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3-24, 1962</u> <b>and that death occurred at</b> <u>11 A.M.</u> <b>from the causes and on the date stated above,</b>							
<b>22a. SIGNATURE</b> <u>David J. Gilmore</u> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>MAR 24, 1962</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>DAVID J. GILMORE</u>				<b>22d. ADDRESS</b> <u>SALISBURY, MARYLAND</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>MAR 27, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>OOD FELLOWS Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>SEAFORD, DELAWARE</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rayner M. Watson</u> ADDRESS <u>SEAFORD, DELAWARE</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 27 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thoma</u>	

8228

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>708 SIXTH STREET</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>BEATRICE</u> <u>ELSIE</u> <u>AYDELOTTE</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH</u> <u>27</u> <u>1962</u>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 5, 1909</u>	
<b>9. AGE</b> (In years last birth day) <u>52</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign, country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Wesley Sturgis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Hester ?</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>214-28-1497</u>			
<b>17. INFORMANT</b> <u>Thomas Aydelotte</u>				<b>Address</b> <u>Pocomoke City, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491x</u> <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>7 days</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3-25, 1962</u> , <b>to</b> <u>3-27, 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3-27, 1962</u> , <b>and that death occurred at</b> <u>7:10 PM</u> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Willie S. Ellis, Jr.</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3-27-62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, or other disposal (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-30-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hall's Hill Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Pocomoke City, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Samuel Sarg</u>				<b>ADDRESS</b> <u>New Church, Va.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 2 '62</u>	
						<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>	

03830

CHURCHILL'S BARN

1884

(M)

(1)

No. —  
at 22-111 Thomas H. H. H. H.  
Weekly Studies  
How with Maryland  
Dec 21-1909

General and Mr. H. H. H. H.  
New Church



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03885

## CERTIFICATE OF DEATH

03881

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> d. STREET ADDRESS <u>800 STATE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Lee Samuel Baker</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 23, 1962</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-20-1894</u>
<b>9. AGE</b> (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RT. ENGINEER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>RAILROAD</u>	
<b>13. FATHER'S NAME</b> <u>SETH BAKER</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ANGIE ESHAM</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>YES WW I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>717-09-2737</u>	
<b>17. INFORMANT</b> Address <u>LIZZIE BAKER - DELMAR - MD</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (e), stating the underlying cause last. DUE TO (c) _____	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/22, 1962</u> <b>to</b> _____ <b>19</b> _____ <b>that (I) (we) last saw the deceased alive on</b> <u>3/23, 1962</u> <b>and that death occurred at</b> <u>2:30 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>David J. Gilmore</u>		<b>22b. DATE SIGNED</b> M.D. <b>22c. PHYSICIAN'S NAME (Type)</b> <u>W.S. Marvel Co - Delmar, Del.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>3-26-62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. OLIVE</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>DELMAR - DEL.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.S. Marvel Co - Delmar, Del.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 27 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03885

CERTIFICATE OF DEATH

03881

M

T

Charles Thompson

Wm. J. Miller

3/12/22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03886											
03882											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parsonsbury</u> d. STREET ADDRESS <u>-----</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dale</u> <u>Berger</u> 4. DATE OF DEATH Month Day Year <u>March</u> <u>10</u> <u>19 62</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24, 1911</u>		9. AGE (In years last birthday) <u>50 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---Self-employed---</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry H. Berger</u>						14. MOTHER'S MAIDEN NAME <u>Anna O'Meara</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>***</u>						16. SOCIAL SECURITY NO. <u>361-03-1233</u>		17. INFORMANT <u>Hospital Records --- Salisbury, Maryland</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung - right</u> DUE TO (b) <u>with multiple metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6 mon</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/8/62</u> , 19 <u>62</u> , to <u>3/10/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/10/62</u> , 19 <u>62</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Lee L. Lawry</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>March 10, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>						22d. ADDRESS <u>Deer's Head State Hospital - Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 12, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) <u>Salisbury, Maryland</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co., Salisbury, Maryland</u> ADDRESS						25a. REC'D BY REGISTRAR <u>MAR 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

03882

CHRYSLER OF DEATH

03882



*Continuation of log - right  
with number notation*

*Lee Harvey*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03887

CERTIFICATE OF DEATH

03883

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING HILL SANITARIUM</u>		d. STREET ADDRESS <u>WASHINGTON ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL CARLETON BIRCH</u>		4. DATE OF DEATH Month Day Year <u>MAR. 14 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 21, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES BIRCH</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. PROPPER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT Address <u>Mrs. CARL C. BIRCH BERLIN MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>502.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cor Pulmonale</u> (c) <u>Emphysema and Chronic Bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Jan. 19, 1962</u> to <u>March 14, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1962</u> , and that death occurred at <u>5:17 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill</u> M.D.		22b. DATE SIGNED <u>3/17/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas C. Hill</u>		22d. ADDRESS <u>Pine Bluff Rd, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/17/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BOWEN</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amie A. Bulbye</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03888

Items 8 & 9 Film G310 4/5/62 mh

03884

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY in 1b <u>4 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>XEDEN</u>	
3. NAME OF DECEASED (Type or print) First <u>Greensbury</u> Middle <u>Bivens</u> Last <u>Bivens</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Dec. 7, 1910</u>	9. AGE (In years last birthday) <u>51</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Princess Anne, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>		13. FATHER'S NAME <u>Sydney Bivens</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Hergis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> 16. SOCIAL SECURITY NO. <u>212-12-3356</u> 17. INFORMANT <u>Alice Bivens, Princess Anne, Md</u> Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete Renal Shut down.</u> 593X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Nephritis</u> (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>  </u> 19 <u>  </u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/25/62</u> , 19 <u>  </u> , to <u>3/25/62</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>3/25/62</u> , 19 <u>  </u> , and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Cassie Hearn</u> M.D.		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLIE HEARN</u>		22d. ADDRESS <u>226 W. Lincoln St Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/1/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Mary</u>		23d. LOCATION (City, town or county) (State) <u>West Post office, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u> ADDRESS <u>Princess Anne, Md</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	
DATE <u>APR 3 '62</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03889  
CERTIFICATE OF DEATH  
03885

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury,</b>		c. LENGTH OF STAY IN 1b <b>Since 8/23/58</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pine Bluff State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Margaret</b> Last <b>Borg</b>		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/8/1888</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME (First name) <b>WILHELM Schutz</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Ganshorn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>87-268-329</b>	
17. INFORMANT <b>Records of Pine Bluff State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>002</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 23, 1958</b> , to <b>March 31, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 31, 1962</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. P. Ritchings</b>		22b. DATE <b>March 31, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr. 3, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>	23d. LOCATION (City, town or county) (State) <b>Denton Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Virginia H. H. H. H.</b>		25a. REC'D BY REGISTRAR <b>APR 5 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. H. H.</b>			

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03886									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			d. STREET ADDRESS <u>312 Park Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Angla Jean Boulter</u>					4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1962</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 2, 1961</u>		9. AGE (In years last birthday) yrs. <u>6</u> Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Joseph Albert Boulter</u>					14. MOTHER'S MAIDEN NAME <u>Rebecca Ann Collins</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Father- as above.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic sub-dural hemorrhage</u> <u>983X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child apparently had been beaten at home.</u>									INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>
20c. TIME OF INJURY Hour <u>?</u> a.m. <u>1-31-62</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own home</u>		20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>					DATE SIGNED <u>3-19-62</u>				
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>3-20-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Salisbury Md.</u>
23. FUNERAL DIRECTOR <u>Holloway and Co.</u>					ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and the attending physician has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03891

CERTIFICATE OF DEATH

03887

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>XXXXXXX Balto</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>4107 Maine Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route # 3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSHUA BAKER BRYAN</b>				4. DATE OF DEATH Month Day Year <b>MARCH 25th 19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <u>MARRIED</u> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 7, 1887</b>	9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months Day <b>6 18</b>	IF UNDER 24 HRS. Hours Min. <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Foreman-Chemical Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seaford, Delaware</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Baker Bryan</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Messick</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mrs. Martha Bryan (Wife) 4107 Maine Avenue Baltimore 7, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Thrombosis</b> <b>4500</b> DUE TO <b>Fracture of Hip.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arteriosclerotic changes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 mths</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>N/A 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (1) (this hospital) attended the deceased from <b>Mar 18, 1962</b> to <b>3/25, 1962</b> , that (2) (we) last saw the deceased alive on <b>3/24, 1962</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. B. Smith</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 26/1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>				22d. ADDRESS <b>Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 27 /1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fireman's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sharptown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 27 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

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**FOR STATE**  
**HEALTH DEPT.**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03892

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

038888

1. PLACE OF DEATH e. COUNTY <b>Wicomico</b>	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Delaware</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dagsboro</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>	d. STREET ADDRESS <b>46x3</b>
3. NAME OF DECEASED (Type or print) <b>Robert LeCompte Bunting</b>	4. DATE OF DEATH Month <b>3</b> Day <b>8</b> Year <b>62</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-30</b>
9. AGE (In years last birthday) <b>31</b> yrs.	10. IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	12. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>
13. FATHER'S NAME <b>Frank Bunting</b>	14. MOTHER'S MAIDEN NAME <b>Jennie Quillen</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>22I-18-7695</b>	16. SOCIAL SECURITY NO. <b>Dollie Bunting Dagsboro D</b>
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed skull: crushed chest.</b> <b>823X</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19. INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car that ran off the road and hit parked cars.</b>
20c. TIME OF INJURY Month, Day, Year <b>5:30 P.M. 3-8-62</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route # 26 Gumboro Del.</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>Earl L. Royer, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3-10-62</b>	22. ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury</b> Address (Street, city, town, or country)
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>3/11/62</b>
22c. NAME OF CEMETERY OR CREMATORY <b>Dagsboro</b>	22d. LOCATION (City, town, or country) (State) <b>Del.</b>
23. FUNERAL DIRECTOR <b>Watson &amp; Gray</b>	24. REC'D BY REGISTRAR <b>Gray</b>
25. REGISTRAR'S SIGNATURE <b>Watson &amp; Gray</b>	26. DATE <b>MAR 16 '62</b>

03282

RESEARCH AND DEVELOPMENT OF NEW MATERIALS

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RESEARCH AND DEVELOPMENT OF NEW MATERIALS



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03893

CERTIFICATE OF DEATH

03889

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mardela (Rural)</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Maple Shad Nursing Home</b>			d. STREET ADDRESS <b>R.D.# 5 Quantico Rd</b>		
3. NAME OF DECEASED (Type or print) <b>WILLIE ESTELLE CANTWELL</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>23rd</b> Year <b>1962</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>June 17, 1880</b>		9. AGE (In years last birthday) <b>81</b> yrs. <b>9</b> Months <b>6</b> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Princess Anne, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Sidney Dryden</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Gibbons</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>Mr. Arthur B. Cantwell (Son) Emerson Ave.</b> <b>Mrs. Mary E. C. Davis - (Daughter) Quantico Rd</b> <b>Salisbury, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>General Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>331X</b> (a), stating the underlying cause last. (c) <b>2 weeks</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>N/A</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1960</b> to <b>Mar 23 1962</b> , that (I) (we) last saw the deceased alive on <b>March 25 1962</b> , and that death occurred at <b>9:55 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Dr. H. S. Kuhlman</b>			22b. DATE <b>March 26 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. H. S. Kuhlman</b>
22d. ADDRESS <b>Sharptown, Maryland</b>			22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 26, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>			25a. REC'D BY REGISTRAR <b>SALISBURY, MARYLAND</b>		
25b. REGISTRAR'S SIGNATURE <b>March 27 '62</b>			25c. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03890									
Item 9 Film G310 4/2/62									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millsboro</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>R.F.D. 3</u>				
3. NAME OF DECEASED (Type or print) <u>Edna Florence Collins</u>					4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1962</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/25/1908</u>		9. AGE (In years last birthday) <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAUNDREY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDREY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>WM. DAVIS</u>					14. MOTHER'S MAIDEN NAME <u>EMMA LEWIS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>215-36-1400</u>		17. INFORMANT <u>HARRY COLLINS</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion with myocardial infarct.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a.m.</u> <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>					DATE SIGNED <u>3-21-62</u>				
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>3/24/62</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>MECHANICS CEMETERY</u>					22d. LOCATION (City, town, or country) (State) <u>MILLSBORO DEL.</u>				
23. FUNERAL DIRECTOR <u>Ronald James - Millsboro, Del.</u>					24a. REC'D BY REGISTRAR <u>DATE MAR 27 '62</u>				
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>				

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Wm. Davis

Evania Lewis

Dr. H. H. Hanks, Collins

*[Handwritten signature]*

3/24/84 MECHANICAL DEPARTMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03895

## CERTIFICATE OF DEATH

03891

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>202 Linwood Ave</b>				d. STREET ADDRESS <b>1 202 Linwood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>N/I</b> Last <b>COLONA</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1893</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (Laborer)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Colonna</b>				14. MOTHER'S MAIDEN NAME <b>Martha Jane Truitt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W.# I 214-10-7719</b>		17. INFORMANT Address <b>Mrs. Nellie R. Nelson (Niece) 212 Tilghman St Salisbury, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary thrombosis.</b> DUE TO (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		2Df. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3/30/62</b> to <b>3/30/62</b> , that (I) (we) last saw the deceased alive on <b>3/30/62</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Earl M. Beardsley</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 31/1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b>				22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Apr. 1, 1962</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>APR 2 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>			

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CERTIFICATE OF DEATH

03892

1. PLACE OF DEATH a. COUNTY: <u>POCOMOKE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE: <u>Maryland</u> b. COUNTY: <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>			
c. LENGTH OF STAY IN 1b <u>1 DAY</u>				d. STREET ADDRESS <u>Box 154</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Talbot</u> Last <u>Cook</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 9, 1898</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>ELBERT COOK</u>				14. MOTHER'S MAIDEN NAME <u>ADA HURT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Box 154</u> <u>MRS JENNIE C. COOK, WESTOVER, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic Heart Disease with Aortic Stenosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> 19 <u>62</u> to <u>3/9</u> 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>3/9</u> 19 <u>62</u> ; and that death occurred at <u>11:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED <u>3/9</u>		22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>	
22d. ADDRESS <u>Salisbury, Maryland</u>				22e. REC'D BY REGISTRAR <u>Robert H. Watson</u>		22f. REGISTRAR'S SIGNATURE <u>Robert H. Watson</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-12-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>QUINTON CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>Rural-Pocomoke City, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF DATA

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W. L. WILCO

1 day

1 day

1 day

1 day

W. L. WILCO

W. L. WILCO

W. L. WILCO

W. L. WILCO

W. L. WILCO

W. L. WILCO

No

W. L. WILCO

W. L. WILCO

W. L. WILCO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03897

03893

1. PLACE OF DEATH a. COUNTY <b>Nicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PENINSULA GENERAL Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Church</b> d. STREET ADDRESS <b>New Church, Virginia</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ROBERT</b> First Middle Last <b>CORBIN</b>			4. DATE OF DEATH <b>MARCH 11</b> Month Day Year <b>19 62</b>		
5. SEX <b>MALE</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Aug. 5, 1890</b> 71 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Keeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Accomack, Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George Corbin</b>			14. MOTHER'S MAIDEN NAME <b>Missouri (unknown)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>			16. SOCIAL SECURITY NO. <b>231-14-0213</b>		
17. INFORMANT <b>Thelma Yourison</b> Address <b>Berlin, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>7 days</b> INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3/4/62</b> , 19 <b>62</b> , to <b>3/11</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/11</b> , 19 <b>62</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Hand J. Gilmore</b> M.D.			22b. DATE SIGNED <b>19 62</b>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Mar. 13/62</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Taylor's Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Temperanceville, Virginia</b>		
24 FUNERAL DIRECTOR'S SIGNATURE <b>James H. Fox</b> ADDRESS <b>Temperanceville, Va.</b>			25a. REC'D BY REGISTRAR <b>MAR 19 '62</b> DATE		
			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>		

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Virginia

New York

New York, Virginia

New York, Virginia

Aug. 2, 1900

York, Virginia

Missouri (Kansas)

Yes or No

Yes or No

Yes or No

Yes or No

Yes or No

Yes or No

Yes or No

Yes or No

Yes or No

Yes or No

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03898

03894

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wiconico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards(Rural)</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D.# 1(Willards-Powellville Rd)</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wiconico</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards(Rural)</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WILLIAM</b> Middle <b>EDWARD</b> Last <b>DENNIS</b>		<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>13th</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 14, 1889</b>
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer- Retired</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Wiconico Co., Maryland</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>
<b>13. FATHER'S NAME</b> <b>Jenkins Dennis</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Ellen Cooper</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Mrs. Gertie Mae Dennis (Wife) R.D.# 1 Willards, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Sealed pulmonary tuberculosis. (Institution treated 5 yrs.)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>N/A</b>	
<b>20a. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>N/A</b> <b>19</b>		<b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
<b>20d. (City or town)</b> <b>N/A</b>		<b>20e. (County)</b> <b>N/A</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 19..... to 19....., that (I) (we) last saw the deceased alive on 19....., and that death occurred on 19....., from the causes and on the date stated above.</b> <b>10:15 A.M.</b>			
<b>22a. SIGNATURE</b> <b>Dr. Frank R. Lewis</b>		<b>22b. DATE</b> <b>March 14 / 1962</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Frank R. Lewis</b>		<b>22d. ADDRESS</b> <b>Willards, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Mar. 15, 1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lewis Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> <b>Willards, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 15 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Salisbury, Maryland</b>		<b>25c. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>	

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03899

CERTIFICATE OF DEATH

03895

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>430 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsular General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>SAMUEL</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>10</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10/9/1891</u>
<b>9. AGE</b> (In years last birthday) <u>70</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>	
<b>11. IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Stephen Deshield</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>George Anna Brown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>World War #1</u>		<b>16. SOCIAL SECURITY NO.</b> <u>203-14-2511</u>	
<b>17. INFORMANT</b> <u>Mamie Jones, Jesterville, Md.</u>		<b>18. ADDRESS</b> <u>Jesterville, Md.</u>	
<b>19. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Idiopathic GI Bleeding (Possibly Colonic)</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Possible Neoplastic Changes.</u> DUE TO (c) <u>Arteriosclerotic Heart Disease &amp; Hypertension</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 weeks</u> <u>?</u> <u>?</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>Typhoid-nephritis - Cerebral Sclerosis</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>0</u> e.m. <u>19</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 25, 1962</u> <b>to</b> <u>Mar 10, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Mar 9, 1962</u> <b>and that death occurred at</b> <u>11:30 AM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>G. Herbert Sembly</u> M.D.		<b>22b. DATE</b> <u>Mar 10, 1962</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type or print) <u>G. Herbert Sembly</u>		<b>22d. ADDRESS</b> <u>Salisbury, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>3/13/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Jesterville Cem.</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Jesterville, Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C. H. Messick, Jr.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 13 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>			

03203

THE HEALTH OF GREAT

03203

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*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05171

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARDELA RD</u>		c. LENGTH OF STAY in 1b <u>20 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X MARDELA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RIVERTON</u>				d. STREET ADDRESS <u>1 RIVERTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAC</u> Middle <u>McCREADY</u> Last <u>DICKENSON</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>29</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 9, 1886</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>LAUREL, DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LEVIN DICKENSON</u>				14. MOTHER'S MAIDEN NAME <u>LEUCIA OWENS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>215-38-1114</u>		16. SOCIAL SECURITY NO. <u>215-38-1114</u>		17. INFORMANT Address <u>MRS SADIE B. DICKENSON, MARDELA MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO <u>Chronic Lymphocytic Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>March 31, 1959</u> to <u>March 29, 1962</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>March 11, 1962</u> , and that death occurred at <u>1:30</u> A.M. from the causes set out on the date stated above.							
22a. SIGNATURE <u>Thomas C Hill Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 31, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS C HILL JR</u>				22d. ADDRESS <u>Pine Bluff Road, Salisbury Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-31-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RIVERTON CHURCH</u>		23d. LOCATION (City, town or county) (State) <u>RIVERTON MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home, Shaplehorn road</u>				ADDRESS <u>  </u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03901  
CERTIFICATE OF DEATH  
03896

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY in lb <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u> <u>19X-2</u> d. STREET ADDRESS <u>Beckford Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR P. DRYDEN</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>16</u> <u>1962</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>Aug 28 1894</u> <u>67</u> yrs.			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Lewis Dryden</u>		14. MOTHER'S MARDEN NAME <u>Cora King</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Elizabeth Dryden</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute + Chronic Bronchitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> , 19 <u>62</u> to <u>3/16</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>62</u> , and that death occurred at <u>3:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-18-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew Em.</u>			
23d. LOCATION (City, town or county) <u>Princess Anne, Md</u>		25a. REC'D BY REGISTRAR <u>MAR 20 '62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis Wilson</u> ADDRESS <u>Princess Anne, Md</u>							

03880

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03902

03897

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>2 Wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>12</u> d. STREET ADDRESS <u>120 Pricilla St.</u> <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSHUA LEMUEL DRYDEN</u> First Middle Last		4. DATE OF DEATH <u>MARCH 12 1962</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1906</u>
9. AGE (In years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agency</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rent-A-Car</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13. FATHER'S NAME <u>Walter D. Dryden</u>	
14. MOTHER'S MAIDEN NAME <u>Maude Phillips</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>W. W. II</u>	
16. SOCIAL SECURITY NO. <u>781-05-8110</u>		17. INFORMANT <u>Mrs. J. Lemuel Dryden, Same</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> 5410 } DUE TO (b) <u>Gastric Resection for Bleeding</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Duodenal Ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1957</u> to <u>March 12, 1962</u> that (I) (we) last saw the deceased alive on <u>March 12, 1962</u> , and that death occurred at <u>9:28 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill</u> M.D.		22b. DATE SIGNED <u>3/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas Hill, M.D.</u>		22d. ADDRESS <u>Pine Bluff Rd., Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/15/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co., Salisbury, Maryland</u> ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 16 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

(M)

03002

CERTIFICATE OF DEATH

03803

Name of Deceased		Date of Birth	
John Doe		1900-01-01	
Sex		Male	
Race		White	
Marital Status		Married	
Date of Death		1950-01-01	
Place of Death		New York, NY	
Cause of Death		Heart Disease	
Occupation		Teacher	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		1950-01-05	
Place of Registration		New York, NY	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03903

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03898

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>TURPIN</b> Last <b>DUNN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>9th</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1901</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman for Furnature Co. (Employee) Bivalve, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Franklin S. Dunn</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. Washburn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mrs. Audrey Mae Dunn (Wife) 918 Johnson St Salisbury, Maryland</b>	
17. INFORMANT <b>Mrs. Audrey Mae Dunn (Wife) 918 Johnson St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest</b> 810X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in collision with train</b>	
20c. TIME OF INJURY Hour <b>1:45 pm</b> Month, Day, Year <b>3-9 1962</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway RR Eden Md.</b>	20f. (City or town) (County) (State) <b>Eden Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>March 10 / 1962</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 12, 1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Gardens-Salisbury, Maryland</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>MAR 13 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>

MEDICAL CERTIFICATION

00003

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 12

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03904  
CERTIFICATE OF DEATH  
03899

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>12 Turin Tree Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>Baylor</u> Last <u>Early SR</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15-1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dard W. Early</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Rankin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-5 Govt</u>	
17. INFORMANT <u>Harry B. Early Jr</u>		Address <u>1117-East Church St. Salisbury Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Pulmonary edema</u> DUE TO (c) <u>Decompensated congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>2 Days</u> <u>4 Days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>3-4</u> , 19 <u>62</u> to <u>3-6</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3-4-62</u> 19 <u>62</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George H. Henning</u> M.D.		22b. DATE SIGNED <u>Mar. 6-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>George H. Henning</u>		22d. ADDRESS <u>Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 8-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Southland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ammon Buz</u> ADDRESS <u>1661-1000 Howard St WASH. 20 DC</u>		25a. REC'D BY REGISTRAR <u>8-62</u> DATE <u>8-62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Pines</u>	

03900

STATE OF CALIFORNIA

03900

03905

CERTIFICATE OF DEATH

03900

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>			
c. LENGTH OF STAY IN 1b <u>3 Days</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Essie Spencer Clazy</u>				4. DATE OF DEATH Month Day Year <u>March 13 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/15/1909</u> 52 yrs.	
9. AGE (In years last birthday) <u>52</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>James Albert Spencer</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Quinton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT Address <u>Carrie E. Carter, Phil., Pa.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma - peritoneal</u>							
172X DUE TO (b) <u>Adenocarcinoma fides litri. (endometrial)</u>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13</u> , 19 <u>61</u> , to <u>March 13</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>March 13</u> , 19 <u>62</u> , and that death occurred at <u>12 P.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Stedman W. Smith</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>3/18/62</u>		<u>Sharptown Cem.</u>		<u>Sharptown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. J. Messers, Bivale, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "March" and "April" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03906

CERTIFICATE OF DEATH

03901

1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN <b>MARYLAND</b> <b>92 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs</b> d. STREET ADDRESS <b>---</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Sherman</b> Last <b>ENGLISH</b>		4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 16, 1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>28</b> Hours <b>---</b> Min. <b>---</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-U.S. Mail(Rural)Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wicomico County, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas W. English</b>		14. MOTHER'S MAIDEN NAME <b>Martha Cravenor</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		17. INFORMANT <b>Mrs. Martha A. Engberg (Daughter)</b> Address <b>900 Irvington Road Chester, Pa. (TR-6-5212)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Dis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>5 yrs.</b> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 12, 1961</b> to <b>March 14, 1962</b> that (I) (we) last saw the deceased alive on <b>March 14, 1962</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b> M.D.		22b. DATE SIGNED <b>3/14/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M.D.</b>		22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 17, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Memorial Cen. Mardela, Maryland</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 16 '62</b> DATE <b>Arthur S. Thomas</b>	
25b. REGISTRAR'S SIGNATURE			

03901

DATE OF BIRTH

03901



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Location County, Maryland U.S.A.

Notes: 1. 1011

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May 17, 1962

May 17, 1962

HOLLOWAY & COMPANY

PALISBURY, MARYLAND

VR A15 (4)  
15M 9/60

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**1. GENERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(A)

Hand of John  
Hill B.P.  
Pamela Carpenter

Wesley  
Wesley

Not to be used

FREDERICK  
Wesley

Wesley

Wesley

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03903  
Reg. Dist. No.

03903

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Pittsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In Village</b>				d. STREET ADDRESS <b>In Village</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>ALVIN</b> Last <b>FARLOW</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>18th</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1921</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR <b>9</b> Months <b>17</b> Days		IF UNDER 24 HRS. <b>17</b> Hours <b>17</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>T.V. Repairman-Employee T.V. Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Roy A. Farlow</b>				14. MOTHER'S MAIDEN NAME <b>Winefred Tilghman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>W.W.# II</b>				16. SOCIAL SECURITY NO. <b>Mr. Norman D. Farlow (Brother) R.D.#</b>			
				17. ADDRESS <b>Tilghman Road - Parsonsburg, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burns 90% Body Surface</b> DUE TO <b>916.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Due to</b> DUE TO (c) <b>Interval between onset and death</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>House on fire during night</b>			
20c. TIME OF INJURY Hour a. m. <b>3:18</b> p. m. <b>1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Pittsville</b> (County) <b>Wicomico</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Mar. 21, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>	
				22d. LOCATION (City, town, or county) <b>Pittsville, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>MAR 22 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Royer</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Date of Death: \_\_\_\_\_

6. Place of Death: \_\_\_\_\_

7. Cause of Death: \_\_\_\_\_

8. Manner of Death: \_\_\_\_\_

9. Signature of Medical Examiner: \_\_\_\_\_

10. Signature of Coroner: \_\_\_\_\_

11. Signature of Registrar: \_\_\_\_\_

12. Signature of Physician: \_\_\_\_\_

13. Signature of Nurse: \_\_\_\_\_

14. Signature of Pathologist: \_\_\_\_\_

15. Signature of Forensic Scientist: \_\_\_\_\_

16. Signature of Toxicologist: \_\_\_\_\_

17. Signature of Radiologist: \_\_\_\_\_

18. Signature of Anesthesiologist: \_\_\_\_\_

19. Signature of Surgeon: \_\_\_\_\_

20. Signature of Dentist: \_\_\_\_\_

21. Signature of Pharmacist: \_\_\_\_\_

22. Signature of Veterinarian: \_\_\_\_\_

23. Signature of Other: \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03909

03904

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALSBURY</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westover</u> d. STREET ADDRESS <u>19X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Addie</u> <u>Florence</u> <u>Ford</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>8</u> <u>1962</u>	
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13 1877</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Marion Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME <u>Perry Lankford</u> 14. MOTHER'S MAIDEN NAME <u>Alice Coulbourn</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>W Clyde Ford Westover, Md.</u> 17. INFORMANT Address <u>W Clyde Ford Westover, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X } DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>5 da.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>3-4</u> 19 <u>62</u> to <u>3-8</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3-8</u> 19 <u>62</u> and that death occurred at <u>1:45 P.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>William S. Eccles Jr.</u> M.D. 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED <u>3-8-62</u> 22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-11-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew Em. Princess Anne Md.</u> 23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u> 25a. REC'D BY REGISTRAR <u>Mar 14 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Carter &amp; House</u>		25c. ADDRESS	

1124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03910

## CERTIFICATE OF DEATH

03905

1. PLACE OF DEATH e. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY in 1b <u>25 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u>		d. STREET ADDRESS <u>In Village Court</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel</u> <u>Alice</u> <u>Freeny</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>23</u> <u>19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17, 1876</u>	
9. AGE (In years last birthday) <u>85 yrs.</u>		IF UNDER 1 YEAR Months Days <u>85</u>		IF UNDER 24 HRS. Hours Min. <u>85</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Rev. James L. Elderdice</u>				14. MOTHER'S MAIDEN NAME <u>Unity Virdin/Manshester, N.H.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mr. Lawrence C. Freeny (Son) 41 Seames Drive</u>			
17. INFORMANT <u>Hospital Records -- Salisbury, Maryland</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>N/A</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>N/A</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>N/A</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/26/62</u> to <u>3/23/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/23/62</u> , 19 <u>62</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>V. Juerman</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>March 23, 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>	
22d. ADDRESS <u>Deer's Head Hospital - Salisbury, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 27/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pittsville Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pittsville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 27 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Conrad S. Thomas</u>			

03902

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
03911																			
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>810 Cooper St</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>810 Cooper St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLIFTON WASHINGTON FURBUSH</b>					4. DATE OF DEATH Month Day Year <b>MARCH 27th 1962</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Nov. 18. 1901</b>		9. AGE (In years last birthday) <b>60</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railway Express Agent</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Wetitequin, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>											
13. FATHER'S NAME <b>John W. Furbush</b>					14. MOTHER'S MAIDEN NAME <b>Carrie A. Majors</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>148X</b>					17. INFORMANT <b>Mrs. William F. Godfrey (Daughter) 810 Cooper Street Salisbury, Maryland</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>CARCINOMA PHARYNX</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>N/A 19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>N/A</b>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>									
20f. (City or town) (County) (State) <b>N/A</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 1961</b> to <b>MAR 27, 1962</b> , that (I) (we) last saw the deceased alive on <b>MAR 27, 1962</b> , and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above.										22a. SIGNATURE <b>Dr. H. Gray Reeves M.D.</b>									
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. Gray Reeves</b>					22d. ADDRESS <b>Medical Center-Salisbury, Maryland</b>					22b. DATE SIGNED <b>Mar. 29 / 1962</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>Mar. 29, 1962</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Men. Gardens -Salisbury, Maryland</b>									
23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>					24 FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>					25a. REC'D BY REGISTRAR <b>MAR 30 '62</b>									
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>																			

03211

CONTINUATION OF DEATH

03211

Locomotion

Salisbury

Locomotion

Salisbury

810 Cooper St

810 Cooper St

CLINTON WASHINGTON

CLINTON WASHINGTON

Nov. 18, 1901

Nov. 18, 1901

Retired Railway Express Agent

Retired Railway Express Agent

John. L. Thayer

John. L. Thayer

Mr. William L. Thayer, 1001  
1001 Salisbury, Maryland

Mr. William L. Thayer, 1001  
1001 Salisbury, Maryland

Mr. William L. Thayer, 1001  
1001 Salisbury, Maryland

WA

WA

WA

Mr. L. Gray Reeves

Mr. L. Gray Reeves

Nov. 22, 1902

HOLLOMAN & COMPANY, SALISBURY, MARYLAND

HOLLOMAN & COMPANY, SALISBURY, MARYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03912 CERTIFICATE OF DEATH 03907

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GIRDLETREE</u> <u>23X-2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN</u> <u>farroll</u> <u>GASKILL</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>13</u> <u>1962</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1-1886</u>	9. AGE (In years last birthday) <u>75/7/12</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Messongo, Virginia</u>	
13. FATHER'S NAME <u>Charles Gaskill</u>		14. MOTHER'S MAIDEN NAME <u>Savina Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-36-1560</u>		17. INFORMANT <u>M. Melvin Gaskill, Girdletree, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>March 12, 1962</u> to <u>March 13, 1962</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>March 12, 1962</u> , and that death occurred at <u>2:58 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/13/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas C. Hill, Jr.</u>		22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial March 1962</u>		23b. DATE THEREOF <u>March 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Girdletree, Md</u>		23e. REC'D BY REGISTRAR <u>Mar 15 '62</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Dennis, Snow Hill, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>			

02807

02807

(M)

# 1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the funeral director, or by the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the funeral director, or by the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the funeral director, or by the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03908

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN b. <u>19X-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Westover</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vernon Lee Glover</u>				4. DATE OF DEATH Month Day Year <u>3-29-1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/7/61</u>		9. AGE (In years last birthday) <u>5</u> yrs.	IF UNDER 1 YEAR Months Days <u>5</u>	IF UNDER 24 HRS. Hours Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Grover Weatherbe Foster Parent</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Curtis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give number and date of service)		17. INFORMANT <u>Grover Weatherbe Westover, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Salisbury</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-31-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St Paul</u>				22d. LOCATION (City, town, or country) <u>Revel Neck Md</u>			
23. FUNERAL DIRECTOR <u>William H. James Jr. Princess Anne, Md</u>				24a. REC'D BY REGISTRAR <u>APR 5 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AISME  
5M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**TITLICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

03914

MARYLAND  
03909

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route # 2 Jersey Road</b>		d. STREET ADDRESS <b>Route # 2 Jersey Road</b>	
3. NAME OF DECEASED (Type or print) <b>Georgia Irene Goslee</b>		4. DATE OF DEATH <b>3-21-62</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>AA</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-8-24</b>	
9. AGE (in years last birthday) <b>38</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>21</b>	
11. IF UNDER 24 HRS. Hours <b>19</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Shellie Wright</b>		14. MOTHER'S MAIDEN NAME <b>not known</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Patricia Wright</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <b>322.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Acute Alcoholism</b> <b>Chronic Alcoholism</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>none</b> <b>20 yrs</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		DATE SIGNED <b>3-23-62</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Acres Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury md</b>	
23. FUNERAL DIRECTOR <b>Dexter H. Weir</b>		24a. REC'D BY REGISTRAR DATE <b>APR 9 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

010000

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

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U. S. DEPARTMENT OF JUSTICE



VR A15 (4  
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James L. Davis Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03916

## CERTIFICATE OF DEATH

03911

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>180 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>				e. STREET ADDRESS <b>306 Hampden Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>Ina Mae Hargis</b>				4. DATE OF DEATH <b>March 6 19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 3, 1896 66</b>	
9. AGE (In years last birthday) <b>66 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>Domestic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sidney Cottman</b>				14. MOTHER'S MAIDEN NAME <b>Annie Stevenson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Earvine Hargis 306 Hampden Ave. Princess Anne, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tumor of base of brain</b> 237X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 7, 1961</b> , to <b>Mar. 6, 1962</b> , that (I) (we) last saw the deceased alive on <b>Mar. 5, 1962</b> , and that death occurred at <b>4:55 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>V. Juerman</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3/6/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>				22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-11-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Princess Anne, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel Long</b>				ADDRESS <b>New Church</b>		25a. REC'D BY REGISTRAR <b>MAR 14 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hargis</b>			



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ON

3-11-65

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the funeral director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03917

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03912

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>51 Years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>253 Church St.</b>			
3. NAME OF DECEASED (Type or print) <b>Grace</b>				4. DATE OF DEATH Month <b>3</b> Day <b>1</b> Year <b>62</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/10/1910</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Privet Family</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Walter Maddox</b>				14. MOTHER'S MAIDEN NAME <b>Laura Person</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Walter Maddox Princess Anne, Maryland</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Ruptured myocardial aneurysm</b>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>3-3-62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/5/62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>				22d. LOCATION (City, town, or country) (State) <b>Princess Anne, Maryland</b>			
23. FUNERAL DIRECTOR <b>Samuel B. Wright</b>				24a. REC'D BY REGISTRAR <b>7 '62</b>			
ADDRESS <b>Princess Anne, Md</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			

03015



General L. B. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03918  
Item 14 Film G510 4/6/62 iwk  
03913

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in lb <u>2,415 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u> <u>20X-2</u> d. STREET ADDRESS <u>Bellevue Road</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Augustus</u> Middle <u>Dophus</u> Last <u>Hayman</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>29</u> Year <u>19 62</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAR. 10, 1889</u>		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>WEST VIRGINIA</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>CHARLES HAYMAN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Handy</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>				<b>16. SOCIAL SECURITY NO.</b> <u>217-05-7154</u>				<b>17. INFORMANT</b> <u>PEARL U. COULBOURNE</u> Address <u>Marion Md</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422222 } DUE TO <u>Arteriosclerosis, general</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>  </u> (b) <u>  </u> (c) <u>  </u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> Years <u>  </u> Years <u>  </u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Trachea bronchitis and pyelonephritis</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Aug. 18</u> , 19 <u>55</u> , to <u>Mar. 29</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Mar. 28</u> , 19 <u>62</u> , and that death occurred at <u>7:25 A.M.</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>V. Juerman</u> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>3/29/62</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>V. Juerman, M. D.</u>				<b>22d. ADDRESS</b> <u>Deer's Head State Hospital; Salisbury, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>April 1, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Marion</u>				<b>23d. LOCATION</b> (City, town or county) <u>Marion Station</u> (State) <u>md</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anthony E. Ward</u>				<b>ADDRESS</b> <u>Cresford Md</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 4 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Huns</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03919

CERTIFICATE OF DEATH

03914

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	c. LENGTH OF STAY IN 1b <b>4 Wks.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>1 LILLIAN St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>NORTON</b> Last <b>HAYWARD</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 30, 1888</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck</b>	11. BIRTHPLACE (State or foreign country) <b>Delaware (Sussex)</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Hayward</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Lewis</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>	
16. SOCIAL SECURITY NO. <b>A158P-4066</b>		17. INFORMANT Address <b>Mrs. Lena Hayward, Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, due to Pseudomonas</b> DUE TO (b) <b>and Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis, Pyelonephritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 4, 1962</b> to <b>March 2, 1962</b> that (I) (we) last saw the deceased alive on <b>March 1, 1962</b> and that death occurred at <b>7:18</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas C. Hill</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Thomas C. Hill M. D.</b>		22d. ADDRESS <b>Pine bluff Rd. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 5, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co., Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 7 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Norman T. Baber</b>			

10000

CERTIFICATE OF DEATH

10000

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03920  
03916

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN TB <u>Adm. 3-12-62</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hebron</u> d. STREET ADDRESS <u>Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORA</u> <u>Hilghman</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>20</u> <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1898</u> <u>January 23-1888</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>1</u> <u>27</u>	
11. IF UNDER 24 HRS. Hours Min. <u>1</u> <u>27</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Smack</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>N/A</u>	
17. INFORMANT <u>Mr. James C. Hilghman (Husband)</u> <u>Hebron, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Carcinoma of Rt. Lung</u> DUE TO (c) <u>163X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>N/A</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> , 19 <u>62</u> to <u>3/20</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>3/20</u> , 19 <u>62</u> , and that death occurred at <u>3:25</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill Jr</u> M.D.		22b. DATE SIGNED <u>3/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr</u>		22d. ADDRESS <u>Pine Bluff Road Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Mem. Gardens- Salisbury, Maryland</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		25a. REC'D BY REGISTRAR <u>MAR 22 '62</u>	
ADDRESS <u>SALISBURY, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. House</u>	

03016

03320



January 22-1988

D. G. Gosselin, M. D.

House of Representatives

Thomas G. Gosselin

Barth Davis

Mr. Thomas G. Gosselin (House)

N/A

N/A

N/A

Dr. Thomas G. Gosselin Jr.

Born: 1912, 1000 Spring Hill Ave., Jackson, Mississippi

WOLFE & COMPANY - BILLSBURY, MARYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03921

## CERTIFICATE OF DEATH

03917

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George ALLEN Hopkins</u>				4. DATE OF DEATH <u>March 14 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/26/1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Emily Austin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Edna Hopkins, R7D#1 Princess Anne Md</u>			
17. INFORMANT <u>Edna Hopkins, R7D#1 Princess Anne Md</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/13</u> , 19 <u>62</u> to <u>3/14</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/14</u> , 19 <u>62</u> and that death occurred at <u>1230</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		23d. LOCATION (City, town or county) (State) <u>Mt. Vernon Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hanner</u>				25a. REC'D BY REGISTRAR <u>WAR 19 62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanner</u>	

1229



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03922

CERTIFICATE OF DEATH

03918

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pittsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Railroad Ave		d. STREET ADDRESS Railroad Ave	
3. NAME OF DECEASED (Type or print) First Middle Last SARAH ELIZABETH HOYLE		4. DATE OF DEATH Month Day Year MARCH 8th 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1867
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days 6 22	11. IF UNDER 24 HRS. Hours Min. 12. CITIZEN OF WHAT COUNTRY? U S A
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lemuel Truitt		14. MOTHER'S MAIDEN NAME Caroline Elizabeth Hickman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Flora Jones (Daughter) Railroad Ave. Pittsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. N/A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> N/A	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 3/7/62 to 3/7/62, that (I) (we) last saw the deceased alive on 3/7/62, and that death occurred at 4:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Earl M. Beardsley		22b. DATE SIGNED March 7/1962	
22c. PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley		22d. ADDRESS Maryland Ave. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 10, 1962	
23c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		23d. LOCATION (City, town or county) (State) Pittsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR MAR 12 1962	
25b. REGISTRAR'S SIGNATURE Arthur B. Adams		25c. REGISTRAR'S SIGNATURE	

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TO "HOSPITAL" OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03923

Items 13 & 14 Film G310 4/2/62 mh

CERTIFICATE OF DEATH

03919

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Wicomico</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Delaware</u> b. COUNTY <u>Selbyville</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Springhill Sanitarium</u>		d. STREET ADDRESS <u>46 X 3</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Sarah Catherine Hudson</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>3 19 19 62</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2-16-1880</u>
<b>9. AGE</b> (In years last birthday) <u>82</u>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Worcester, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Josiah Hudson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Hudson</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>	
<b>17. INFORMANT</b> <u>Florence Hudson - Selbyville, Del.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis, advanced</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease + Uremia</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>Unknown</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/19</u> , 19 <u>62</u> , <b>to</b> <u>3-19-</u> , 19 <u>62</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3/18</u> , 19 <u>62</u> , <b>and that death occurred at</b> <u>1:15 P.M.</u> <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>Harold J. Wilson</u> M.D.	
<b>22b. DATE SIGNED</b> <u>3-19-62</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Harold J. Wilson</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/21/62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Red Men's</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Selbyville Del.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Henry W. Watson, Jr. Pocomoke City, Md.</u>		<b>25. REC'D BY REGISTRAR</b> <u>23 62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm. S. Thoms</u>		<b>25c. REGISTRAR'S SIGNATURE</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03924					03920						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY		Wicomico			a. STATE		Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Salisbury			b. COUNTY		Caroline				
c. LENGTH OF STAY IN 1b		23 days			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Federalburg				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Deer's Head State Hospital			d. STREET ADDRESS		Davis Lane				
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
Agnes			Viola		Hughes		March		1 19 62		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		Colored				November 6, 1898		63 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housework			Home			Federalburg, Maryland			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Irving Robinson					Christina Dickerson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No			Unknown		Grace Hughes, Philadelphia, Pa.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis due to arteriosclerosis, general. 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)									1 1/2 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1962 to March 1, 1962 that (I) (we) last saw the deceased alive on March 1, 1962, and that death occurred at 6P M, from the causes and on the date stated above.											
22a. SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED			
V. Juerman					M.D.			3/2/62			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
V. Juerman, M. D.					Deer's Head Hospital; Salisbury, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county)			(State)	
Burial		March 6, 1962		Federal Hill Cemetery			Federalburg, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J. J. Frampton and Son, Federalburg, Maryland							DATE MAR 9 '62		Arthur S. Hanks		

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Item 9 Film G310 4/4/62 1wk

## CERTIFICATE OF DEATH

03921

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>412 Ann Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE FOUNTAIN</u>		4. DATE OF DEATH <u>March 29, 1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1900</u>	
9. AGE (In years last birthday) <u>61 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Auto Mechanic</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
15. FATHER'S NAME <u>Fountain Humphreys</u>		16. MOTHER'S MAIDEN NAME <u>Maggie Cordrey</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		18. SOCIAL SECURITY NO. <u>W.W.# 1</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>3/20, 1962</u> to <u>3/29, 1962</u> that (1) (we) last saw the deceased alive on <u>3/29, 1962</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm B Smith</u>		22b. DATE SIGNED <u>3/29/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>		22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 31, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		25a. REC'D BY REGISTRAR <u>APR 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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030021

Salisbury, Maryland

Salisbury, Maryland

Salisbury, Maryland

July 6, 1950

Salisbury, Maryland

Salisbury, Maryland

Salisbury, Maryland

Salisbury, Maryland

Salisbury, Maryland

Salisbury, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5, FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 7/5 (4)  
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03926													
03922													
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>Lynchburg Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>(Sarah) Sally K. Hunter</b>						4. DATE OF DEATH Month Day Year <b>March 8 19 62</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 6, 1888</b>		9. AGE (in years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Laborer Ret.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Queen Anne Co. Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>John Frank Jones</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Kate ? Jones</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>215-12-6066</b>		17. INFORMANT <b>Hospital Records Salisbury, Md.</b> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Perforating peptic ulcer</b>												INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 20, 1962</b> , to <b>March 8, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 8, 1962</b> , and that death occurred <b>1:50 P.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>3/8/62</b>				
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>						22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 11, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Cem.</b>		23d. LOCATION (City, town or county) <b>Church Hill, Md.</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>						ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 12 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and return them to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03927

03923

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>82</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHINCOTEAGUE</u> <u>83X-3</u> d. STREET ADDRESS <u>611 S. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HELEN Emily Jester</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 3, 1962</u>	
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>AUG 15 1932</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SELF</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>NEWARK DEL.</u>
<b>13. FATHER'S NAME</b> <u>William JONES</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MILDRED YOUNG</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>EA 91287</u>	
<b>17. INFORMANT</b> <u>ERNEST JESTER-CHINCOTEAGUE</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>URETERAL OBSTRUCTION "FROZEN PELVIS"</u> (c) <u>EPIDERMOID CARCINOMA CERVIX Uteri</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MARCH 2, 1962</u> <b>to</b> <u>MARCH 3, 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>MARCH 3, 1962</u> <b>and that death occurred at</b> <u>1 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Robert Lee Baker</u> M.D.		<b>22b. DATE SIGNED</b> <u>MARCH 4 1962</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert Lee Baker</u>		<b>22d. ADDRESS</b> <u>Salisbury, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>3-6-62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GREENWOOD</u>	<b>23d. LOCATION (City, town or county)</b> (State) <u>CHINCOTEAGUE</u> <u>DE</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Baker</u>		<b>25. REC'D BY REGISTRAR</b> <u>NO</u> <b>DATE</b> <u>MAR 1 1962</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm. S. Hume</u>			

03823

03823



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03928

CERTIFICATE OF DEATH

Items 5 & 6 Film G308 3/14/62 iwk

03924

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>1683 Fitzwater ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Johnson</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>5</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 3, 1899</u>
<b>9. AGE</b> (In years last birthday) <u>82</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Saloon</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>M. S. A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>M. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>John Johnson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Amanda?</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Wae Buckhead Fitzwater</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Chronic artery disease</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>  </u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> <u>Salisbury</u> (County) <u>  </u> (State) <u>  </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/28/62</u> <b>to</b> <u>3/5/62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3/5/62</u> <b>and that death occurred at</b> <u>7 A.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>David Phargy</u>		<b>22b. DATE SIGNED</b> <u>  </u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>David Phargy</u>		<b>22d. ADDRESS</b> <u>Peninsula General Hospital</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u>		<b>23b. DATE THEREOF</b> <u>3/8/1962</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt Calvary</u>		<b>23d. LOCATION</b> (City, town or county) <u>Fruitland Md.</u> (State) <u>  </u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur F. Stewart</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		<b>DATE</b> <u>MAR 12 '62</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

UNFUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03929						03925					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Wicomico</i>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>			a. STATE <i>MARYLAND</i>			b. COUNTY <i>WICOMICO</i>		
c. LENGTH OF STAY IN 1b <i>12</i>			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>PENINSULA GENERAL Hospital</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>			d. STREET ADDRESS <i>1</i>		
3. NAME OF DECEASED (Type or print) <i>Myrtle S</i>			First <i>Myrtle S</i>			Middle <i>Johnson</i>			Last <i>Johnson</i>		
4. DATE OF DEATH <i>MARCH 25 1962</i>		Month <i>MARCH</i>		Day <i>25</i>		Year <i>1962</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/2/1902</i>		9. AGE (In years last birthday) <i>59</i> yrs.		IF UNDER 1 YEAR Months <i>59</i>		IF UNDER 24 HRS. Days <i>59</i>		Hours <i>59</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>UPSHUR BELOTE</i>		14. MOTHER'S MAIDEN NAME <i>STELLA CHURN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>215-26-0987</i>		17. INFORMANT <i>NORMAN JOHNSON, PARKSLEY, VA.</i>		Address <i>PARKSLEY, VA.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>urinary obstruction</i> DUE TO (c) <i>Melastotic Carcinoma Cervix epididymoid</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1-27-62</i> to <i>3-25, 1962</i> that (I) (we) last saw the deceased alive on <i>3-25-1962</i> and that death occurred at <i>7:20 PM</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Robert Lee Baker</i>						M.D. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>3/27/1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARKSLEY</i>				23d. LOCATION (City, town or county) (State) <i>PARKSLEY VA.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry M. Johnson</i>						ADDRESS <i>PARKSLEY, VA.</i>			25a. REC'D BY REGISTRAR DATE <i>MAR 30 '62</i>		
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Finney</i>					

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FOR STATE  
HEALTH DEPT.

REPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be obtained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03931  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
03927

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 222 Catherine St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian Gertrude Jones		4. DATE OF DEATH 3-17-62		5. SEX F		6. COLOR OR RACE AA		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-28-97		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Slemon Johnson		14. MOTHER'S MAIDEN NAME Lula Horsey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ola Lemon Salisbury und		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-200 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus		19. INTERVAL BETWEEN ONSET OF DEATH 1 year		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		23. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
25. CITY OR TOWN Salisbury		26. COUNTY Wicomico		27. STATE Maryland		28. DATE SIGNED 3-19-62		29. CHIEF MEDICAL EXAMINER Earl L. Royer, M.D.		30. ASSISTANT MEDICAL EXAMINER		31. DEPUTY MEDICAL EXAMINER		32. DATE SIGNED	
33. ACTUAL SIGNATURE Earl L. Royer, M.D.		34. EXAMINER'S NAME (Type) Earl L. Royer, M.D.		35. ADDRESS 407 Camden Ave. Salisbury Md.		36. DATE OF BIRTH 3-24-62		37. NAME OF CEMETERY OR CREMATORY Green Acres Cem		38. LOCATION (City, town, or country) Salisbury Md.		39. STATE Md.		40. REC'D BY REGISTRAR MAR 22 '62	
41. FUNERAL DIRECTOR James B. Schell, Carter, Md.		42. ADDRESS		43. DATE		44. REGISTRAR'S SIGNATURE Arthur S. Thomas		45. DATE		46. REGISTRAR'S SIGNATURE		47. DATE		48. REGISTRAR'S SIGNATURE	

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3-28-97

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 3, should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03932		Item 9FilmG310 4/9/62 iwk		03928							
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>S Walston Switch</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Walston Switch</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<u>Annabelle</u>			<u>Justice</u>			<u>3-15-62</u>			<u>19</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16 - 26</u>		9. AGE (In years last birthday) <u>35 7/8</u> yrs.		IF UNDER 1 YEAR	
										Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>not known</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>225-32178</u>				17. INFORMANT <u>Broader Justice</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
DUO TO <u>4 43 X</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio-vascular disease</u>										Years	
DUO TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-17-62</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THROU <u>3-18-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Jerusalem</u>			
23. FUNERAL DIRECTOR <u>Barber M. Cest</u>				22d. LOCATION (City, town, or country) <u>Thomsville Va</u>				22e. ADDRESS (Street, city, town, or county)			
24a. REC'D BY REGISTRAR <u>22 2 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3, should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. File pages 1 and 2 with the State Board of Health.

VS. AISME  
5M 9/60

03933  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
03929

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1107 Lake St.</u>		d. STREET ADDRESS <u>1107 Lake St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Kennedy</u> Last <u></u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Elsie Kennedy</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4-20-60</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease.</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> e.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>3-3-62</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-7-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		22d. LOCATION (City, town, or country) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR <u>Booker M. West</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Pinner</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03934 CERTIFICATE OF DEATH 03930

1. PLACE OF DEATH a. COUNTY <u>Nicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUS.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>	
c. LENGTH OF STAY in 1b <u>4 DAYS</u>		d. STREET ADDRESS <u>705 JEWEL STREET</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD CLAYTON KIRK</u>		4. DATE OF DEATH Month Day Year <u>MARCH 8 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1878</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED AGENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEO. W. KIRK</u>		14. MOTHER'S MAIDEN NAME <u>MATILDA WINTERBOTTOM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>716-01-6787</u>	
17. INFORMANT Address <u>NELLIE KIRK - DELMAR - DEL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>540.0</u> DUE TO <u>Large Bleeding gastric ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polycystic disease of kidneys</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> , 19 <u>62</u> to <u>3.8</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3.8</u> , 19 <u>62</u> , and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>H A Bricle</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3.9.62</u>	
22c. PHYSICIAN'S NAME (Type) <u>H A Bricle</u>		22d. ADDRESS <u>Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-10-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>M.E.</u>		23d. LOCATION (City, town or county) (State) <u>DELMAR - DEL</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marnal Co - Delmar</u>		ADDRESS <u>Delmar</u>	
25a. REC'D BY REGISTRAR <u>W.S. Marnal Co - Delmar</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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1893-1894

RECEIVED FROM THE ROAD

Geo. W. Kirk

NEW YORK

My dear Mr. Kirk

Yours truly  
W. B. E. B.

W. B. E. B.

1893

## MEDICAL CERTIFICATION

VK 215 (4)  
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From Charles C. Boston, Wash.  
Box 3-7-L-2 Washington D.C.

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

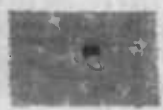
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03932

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>753 Church St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Maddox</u> Last <u></u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>62</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/1887</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Princess Anne, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Justic</u>				14. MOTHER'S MAIDEN NAME <u>Lottie Maddox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>War I</u>				17. INFORMANT <u>Charlotte Gayles, Princess Anne, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO <u>but no scientific proof Dr. Dr. Dr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Right Hip</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of car and struck tree on Camden Ave.</u>			
20c. TIME OF INJURY Hour <u>6 P.M.</u> Month, Day, Year <u>3-1-62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Camden Ave. Salisbury Wicomico Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/19/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>				22d. LOCATION (City, town, or country) (State) <u>Princess Anne, Maryland</u>			
23. FUNERAL DIRECTOR <u>William H. James Jr.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 22 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03937											
03933											
1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>2199 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot County</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oxford</b> d. STREET ADDRESS <b>---</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Elizabeth McLaughlin</b>				4. DATE OF DEATH Month Day Year <b>March 29, 1962</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 5, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Balto Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown Mc Laughlin</b>				14. MOTHER'S MAIDEN NAME <b>Unknown.</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no no</b>				16. SOCIAL SECURITY NO. <b>218-20-3655</b>				17. INFORMANT <b>Mrs. John Thompson. Oxford Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>---</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>11</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1956</b> , to <b>March 29, 1962</b> that (I) (we) last saw the deceased alive on <b>March 28, 1962</b> , and that death occurred at <b>1:05 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>L. V. Maldve</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>3/29/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>				22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Mar. 31, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Oxford Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newman &amp; Son</b>				ADDRESS <b>Easton Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 3 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and 5 and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
c. LENGTH OF STAY in 1b <u>1yr 11mo. 22days</u>				d. STREET ADDRESS <u>5 Douglas Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martina</u> Middle <u>Mollock</u> Last <u></u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1897</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Ejean James</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-09-1783</u>			
17. INFORMANT <u>Lottie Nutter, Nanticoke, Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> 4-20-1 DUE TO <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Pyelonephritis chr.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pyelonephritis chr.</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> el work <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 3</u> , 19 <u>57</u> to <u>Mar. 25</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Mar. 25</u> , 19 <u>62</u> , and that death occurred at <u>12:55 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>V. Juerman</u>				22b. DATE SIGNED <u>Mar. 25, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>				22d. ADDRESS <u>Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Rem-Burial</u>		<u>3/28/1962</u>		<u>Salem Cemetery</u>		<u>Dorchester County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Kline</u>				25a. REC'D BY REGISTRAR <u>Mar 30 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03939

## CERTIFICATE OF DEATH

03935

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b> c. LENGTH OF STAY IN 1b <b>Salisbury (Rural)</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ocean City Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b> d. STREET ADDRESS <b>Ocean City Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IRVING ANDERSON MORRIS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>27th</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1881</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>26</b>	
11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>26</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Levi Morris</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Dillen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>W. Morris (Son) Ocean City Rd. Salisbury, Md.</b>	
17. INFORMANT <b>Mrs. Mary A. Esham Morris (Wife) &amp; Mr. Andrew W. Morris (Son)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> 19 p.m. <b>N/A</b>		20d. INJURY OCCURED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 31, 1962</b> to <b>3/27, 1962</b> , that (I) (we) last saw the deceased alive on <b>3/27, 1962</b> , and that death occurred at <b>5:35 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Earl M. Beardsley</b>		22b. DATE SIGNED <b>March 28 / 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 30, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>MAR 30 '62</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4/5 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03940 Item 9 File 511 4/15/62 iwk 03936

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN TB <u>yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACK</u> <u>MORRIS</u>		4. DATE OF DEATH Month Day Year <u>MARCH 29</u> <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-92</u>
9. AGE (In years and birth day) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathaniel Morris</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Virginia Morris</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Regenerative Heart Disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Indefinite</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>27th</u> <u>1961</u> to <u>29th</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>S. Funnell</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-1-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cape Charles Cem</u>		23d. LOCATION (City, town or county) (State) <u>Cape Charles</u> <u>va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>		25a. REC'D BY REGISTRAR <u>Salisbury</u> DATE <u>APR 9 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03941  
CERTIFICATE OF DEATH  
03937

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b> c. LENGTH OF STAY IN 1b <b>4yrs 7mo 16days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>108 Robbins Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bertha Jones Murphy</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1886</b>
9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Bishops Head, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William I. Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Rhoda Windsor</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Clifford G. Murphy, 813 Roslyn Ave., Cambridge</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Dis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 22, 1957</b> to <b>March 10, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 10, 1962</b> , and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b> M.D.		22b. DATE SIGNED <b>March 10, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, MD</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-13-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DORCHESTER MEMORIAL PARK</b>	23d. LOCATION (City, town or county) (State) <b>CAMBRIDGE, MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>THOMAS FUNERAL HOME, CAMBRIDGE, MD</b>		25a. REC'D BY REGISTRAR <b>MAR 14 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, the undersigned should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03942

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03938

1. PLACE OF DEATH a. COUNTY	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN b	2. USUAL RESIDENCE (Where deceased lived, if Residence before admission)	e. STATE	b. COUNTY		
			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	DUO TO	(b)	DUO TO	(c)	INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)			
23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE				

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# 1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03943 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03939

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>Delmar</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Fries</b> Last <b>O'Neal</b>				4. DATE OF DEATH Month <b>3</b> Day <b>8</b> Year <b>62</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 3, 1891</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rt. Service Station</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline</b>		11. BIRTHPLACE (State or foreign country) <b>Delmar, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry O'Neal</b>				14. MOTHER'S MAIDEN NAME <b>Laura Whaley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>221-05-9835</b>			
17. INFORMANT <b>Edith O'Neal, Delmar, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3-11-62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>				22d. LOCATION (City, town, or country) (State) <b>Delmar, Del.</b>			
23. FUNERAL DIRECTOR <b>W.S. Marvel Co. Delmar, Del.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 14 '62</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03944

03940

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Raymond</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>William H. Parker</u>	
14. MOTHER'S MAIDEN NAME <u>Rosa B. Nicholson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT Address <u>Mrs. I. Florence Parker (Wife) R.D. # 5 (Quantico Rd) Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Regenerative Heart Disease in failure</u> DUE TO (c) <u>sudden</u> 1 wk		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Hour e.m. p.m. <u>N/A</u> 19	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	20f. (City or town) (County) (State) <u>N/A</u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> 19 <u>62</u> to <u>3/17</u> 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>3/17</u> 19 <u>62</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>William D. Gray</u>		22b. DATE SIGNED <u>March 17/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>		22d. ADDRESS <u>Camden Ave. Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		25a. REC'D BY REGISTRAR <u>MAR 20 '62</u>	
ADDRESS <u>SALISBURY, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03945  
CERTIFICATE OF DEATH  
03941

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsborg (Rural)</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>R.D.# 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Norman Albert Perdue</u>		4. DATE OF DEATH <u>March 3 1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28, 1909</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>R.D.#2 Parsonsborg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George W. Perdue</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Adkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		17. INFORMANT <u>Mrs. Pearl E. Perdue (Wife)</u> Address <u>R.D.#2 Parsonsborg, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Atypical pneumonia</u> DUE TO (b) <u>490X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year <u>N/A 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <u>N/A</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) <u>N/A</u> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on <u>March 3 1962</u> , and that death occurred at <u>5:55 P</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilbur R. Ellis Jr</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3-3-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wilbur R. Ellis Jr</u>		22d. ADDRESS <u>Medical Center - Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 7, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery - Walston - R.D.#</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 8 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03946 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03942

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>				c. LENGTH OF STAY IN 1b <b>X Willards</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>XX</b>				d. STREET ADDRESS <b>RFD</b>			
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>Marie</b> Last <b>Peterson</b>				4. DATE OF DEATH Month <b>3</b> Day <b>1</b> Year <b>62</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 22 1884</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>7</b> Min. <b>7</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Sweden</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Oscar Smedberg</b>				14. MOTHER'S MAIDEN NAME <b>Hannah (Unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>XX</b> (If yes give year or dates of service) <b>XX</b>				16. SOCIAL SECURITY NO. <b>XX</b>			
17. INFORMANT <b>Sture Peterson</b>				Address <b>Willards, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive cardio-vascular disease-</b> (c) <b>Years</b> DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				DATE SIGNED <b>3-3-62</b>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/4/62</b>			
22c. NAME OF CEMETERY OR CREMATOR <b>New Hope</b>				22d. LOCATION (City, town, or country) (State) <b>Willards, Md.</b>			
23. FUNERAL DIRECTOR <b>Peter Whaley</b>				24a. REC'D BY REGISTRAR <b>7 '62</b>			
ADDRESS <b>Salisbury, Del.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasa</b>			

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03947  
CERTIFICATE OF DEATH  
03943

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Since 11/22/61</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pine Bluff State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>313 Charles Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Edwin</b> Last <b>Pote</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1906</b>
9. AGE (In years last birthday) <b>55</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>12</b>	
11. IF UNDER 24 HRS. Hours <b>12</b> Min. <b>1</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Monroe Pote</b>		14. MOTHER'S MAIDEN NAME <b>Lorena Blizzard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-07-2388</b>	
17. INFORMANT <b>Records of Pine Bluff State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Brain</b> (b) <b>Anaplastic carcinoma of lung.</b> (c) <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>163 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 22</b> , 19 <b>61</b> , to <b>March 13</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>March 13</b> , 19 <b>62</b> , and that death occurred <b>8:15 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. P. Ritchings</b> M.D.		22b. DATE SIGNED <b>March 14, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-17-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>First Methodist</b>	23d. LOCATION (City, town or county) (State) <b>Delmar, Del.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Marvel</b> ADDRESS <b>Co. Delmar, Del.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 16 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03948  
CERTIFICATE OF DEATH  
03944

1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>41 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b> d. STREET ADDRESS <b>RFD</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>E.</b> Last <b>PURNELL</b>		4. DATE OF DEATH Month <b>March</b> Day <b>28</b> , Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 2, 1876</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>19</b> Days <b>X</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>David Hoffman</b>	
14. MOTHER'S MAIDEN NAME <b>Betty Ward</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Louise Banks -- RFD Westover, Md.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>332X</b> (c) <b>332X</b> DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Bronchopneumonia, Parkinsonism</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15, 1962</b> to <b>March 28, 1962</b> that (I) (we) last saw the deceased alive on <b>March 28, 1962</b> and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>L. V. Maldve, M.D.</b>		22b. DATE <b>3/28/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>		22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 31, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons -- Crisfield, Md.</b> ADDRESS		25a. REC'D BY REGISTRAR <b>APR 2 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25c. DATE <b>APR 2 '62</b>	

1450

2492

2001. 8. 21

## CERTIFICATE OF DEATH

03949

Item 14 Film G308 3/14/62 iwk

03945

## 1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN

238 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Deer's Head State Hospital

## 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Somerset

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Princess Anne

d. STREET ADDRESS

Rt. 1, Box 67

e. IS RESIDENCE

ON A FARM?

YES ☐ NO ☐

## 3. NAME OF DECEASED

(Type or print)

First

John

Middle

Thomas

Last

Rector

4. DATE OF DEATH

Month

March

Day

1

Year

19 62

## 5. SEX

Male

## 6. COLOR OR RACE

Colored

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

## 8. DATE OF BIRTH

9/21/1898

## 9. AGE (In years last birthday)

63 yrs.

## 10. IF UNDER 1 YEAR

Months Days

## 11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

10b. KIND OF BUSINESS OR INDUSTRY

Hotel

11. BIRTHPLACE (County &amp; State, or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U S A

## 13. FATHER'S NAME

John T. Rector

## 14. MOTHER'S MAIDEN NAME

Rachel Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Address

Margaret Rector, Princess Anne, Md

## 18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Cerebral Thrombosis - Hemiplegia

(b)

DUE TO

Generalized Arteriosclerosis

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

3 yrs.

5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Terminal Bronchopneumonia

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 6, 1961, to March 1, 1962 that (I) (we) last saw the deceased alive on Feb. 28, 1962, and that death occurred at 12:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Lee L. Lawry

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐STAFF PHYS. ☒

22b. DATE SIGNED

3/1/62

22c. PHYSICIAN'S NAME (Type)

Lee L. Lawry, M. D.

22d. ADDRESS

Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Sat., 3/3/62

23c. NAME OF CEMETERY OR CREMATORY

John Wesley

23d. LOCATION (City, town or county)

Princess Anne

Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

DATE

7 '62

25b. REGISTRAR'S SIGNATURE

Arthur L. Thomas



03010

03010

THE BUREAU OF DEATH

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**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03950

03946

1. PLACE OF DEATH a. COUNTY <b>MICOMICO</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institutions: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEWARK</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>23X-2</b>	
3. NAME OF DECEASED (Type or print) <b>Edward</b>		First Middle Last <b>RICHARDSON</b>		4. DATE OF DEATH Month Day Year <b>MARCH 23 1962</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>MARCH 25 1910</b>		9. AGE (In years last birthday) <b>51 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER (DRIVER)</b>		12. KIND OF BUSINESS OR INDUSTRY <b>FEED MILL</b>		13. BIRTHPLACE (County & State, or foreign country) <b>NEWARK MD</b>	
14. FATHER'S NAME <b>WISE RICHARDSON</b>		15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>No</b>		19. INFORMANT Address <b>Mrs. EDW. RICHARDSON NEWARK MD</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of Distal Anterior + Myocardial Bands 2 days</b> <b>7 57</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>For Advanced Atherosclerosis</b> DUE TO (c) <b>Unilateral polycystic kidney</b>		21. INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>			
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
26. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
29. (City or town)		30. (County)		31. (State)	
32. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1962</b> to <b>March 23, 1962</b> that (I) (we) last saw the deceased alive on <b>March 23, 1962</b> and that death occurred at <b>7:57 AM</b> , from the causes and on the date stated above.		33. SIGNATURE <b>David Plarney</b>		34. DATE SIGNED <b>3/23/62</b>	
35. PHYSICIAN'S NAME (Type) <b>David Plarney</b>		36. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		37. ADDRESS <b>Peninsula General Hospital</b>	
38. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		39. DATE THEREOF <b>3/25/62</b>		40. NAME OF CEMETERY OR CREMATORY <b>BOWEN</b>	
41. LOCATION (City, town or county) <b>NEWARK</b>		42. (State) <b>MD</b>			
43. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burboys Berlin and</b>		44. ADDRESS <b>NEWARK</b>		45. REC'D BY REGISTRAR DATE <b>MAR 27 '62</b>	
46. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>					

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

(M)

0-820

STATE OF NEW YORK

03316

New York

MARCH 24 1910

NEWARK, N.J.

UNKNOWN

No.

Mr. EOW RICHARDSON, NEWARK, N.J.

Dear Sir: I have the honor to acknowledge the receipt of your letter of the 17th inst. in relation to the above matter. I am sorry to hear that you are unable to locate the person named in your letter. I will endeavor to locate him for you.

Very respectfully,  
J. J. [Signature]

Enclosed for you are two copies of a report of the [Name] [Address] [City] [State] [Country] [Zip] [Phone] [Fax] [E-mail] [Web] [Social Media] [Other Contact Information]

Very truly yours,  
J. J. [Signature]



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03951

03947

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>83X-3</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) e. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Melfa</u> d. STREET ADDRESS <u>Box 369</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>George Oscar Satchell</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>March 21</u> 19 <u>62</u> Month Day Year					
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>colored</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 18, 1894</u>		<b>9. AGE</b> (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>George Satchell</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Nellie</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) _____				<b>16. SOCIAL SECURITY NO.</b> <u>228-48-2183</u>		<b>17. INFORMANT</b> <u>Louise Satchell - Melfa, Va.</u> Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Hypertensive cardiovascular disease</u> 4 4 X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>centuries</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>3/14/62</u> , 19 <u>62</u> , to <u>3-21</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3-21</u> , 19 <u>62</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>William R. Ellis</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) _____				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> _____				<b>22b. DATE SIGNED</b> <u>3-21-62</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-25-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Boston Cem.</u>		<b>23d. LOCATION</b> (City, town or county) _____ (State) _____ <u>Painter, Virginia</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edgar Wharton - Accomack, Va.</u> ADDRESS _____				<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 27 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Thomas</u>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completely filled in by the attending physician and a third page, if necessary, may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and a third page, if necessary, may be retained by the hospital or attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03917

CERTIFICATE OF SALE

03917

M

1  
The law requires that the death certificate be executed within 24 hours after the death. It must be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03952				Item 7 Film 6509 5/27/62 1wk				03948			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)							
a. COUNTY <b>Wicomico County</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>483 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>				e. STATE <b>Maryland</b>				f. COUNTY <b>Somerset County</b>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First <b>Martha</b>				Middle <b>--</b>				Last <b>SCHOOLFIELD</b>			
5. SEX <b>Female</b>				6. COLOR OR RACE <b>Colored</b>				7. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>4/27/1886</b>				9. AGE (In years last birthday) <b>75</b> yrs.				10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>			
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
13. FATHER'S NAME <b>Downing Tilghman</b>				14. MOTHER'S MAIDEN NAME <b>Lucy</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Ida Wade, Philadelphia, Pa</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b>											
443X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <b>Arteriosclerosis, general</b>	
										(c) <b>Arteriosclerosis, general</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 16, 1960</b> , to <b>March 11, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 11, 1962</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>V. Juerman</b>										22b. DATE <b>3/11/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>										22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										23b. DATE THEREOF <b>3/19/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Christ M E</b>										23d. LOCATION (City, town or county) (State) <b>Pocomoke Md. R F D</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James J Jr</b>										25a. REC'D BY REGISTRAR <b>MAR 21 '62</b>	
ADDRESS										25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

03222



03212

CERTIFICATE OF DATA

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1  
The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completely filled in by the attending physician at the time of death. Pages 3 and 4 should be filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, and in any event, within 72 hours after death be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03953

CERTIFICATE OF DEATH

03949

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DEL.</u> b. COUNTY <u>Sussex</u> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD</u> <u>46X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAWN</u> <u>LYNN</u> <u>Selby</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>19</u> <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-62</u>
9. AGE (In years last birthday) <u>2</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>2</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico - MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sampson Selby</u>		14. MOTHER'S MAIDEN NAME <u>Constance Helena Fryer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>SAMPSON SELBY - FRANKFORD DEL.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> 762-5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Immaturity</u> (c) <u>Placental insufficiency</u> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>	
20h. (State) <u>—</u>		20i. (City or town) <u>—</u>	
20j. (County) <u>—</u>		20k. (State) <u>—</u>	
21. I certify that (1) (this hospital) attended the deceased from <u>3/19</u> <u>1962</u> to <u>3/19</u> <u>1962</u> That (1) (we) last saw the deceased alive on <u>3/19</u> <u>1962</u> , and that death occurred at <u>9:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. B. Smith</u> M.D.		22b. DATE SIGNED <u>3/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>—</u>		22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/20/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Red Mens CEMETERY</u>
23d. LOCATION (City, town or county) <u>SELBYVILLE</u>		23e. (State) <u>DEL.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Watson &amp; Gray</u>		24a. ADDRESS <u>Frankford, Del.</u>	
24b. REC'D BY REGISTRAR <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	
24d. DATE <u>MAR 21 '62</u>		24e. (City, town or county) <u>—</u>	
24f. (County) <u>—</u>		24g. (State) <u>—</u>	

03819

UNITED STATES OF AMERICA

03819



STANDARD GENERAL HOSPITAL

STANDARD GENERAL HOSPITAL



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03954

03950

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>16 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Worcester</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> d. STREET ADDRESS <u>113 Broad Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Webster</u> Last <u>Seward</u>				<b>4. DATE OF DEATH</b> Month <u>MAR.</u> Day <u>3</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov. 16, 1888</u>			
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PHARMACIST</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>CENTERVILLE MD</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>GEORGE SEWARD</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>CHARLOTTE MILBY</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-10-9431</u>		<b>17. INFORMANT</b> <u>Hospital Records -- Salisbury, Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate Gland w/metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/15/62</u> <b>19</b> <b>to</b> <u>3/3/62</u> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <u>3/3/62</u> <b>19</b> <b>and that death occurred at</b> <u>7:00 AM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>V. Juerman</u>				<b>22b. DATE SIGNED</b> <u>March 3, 1962</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>V. Juerman, M. D.</u>				<b>22d. ADDRESS</b> <u>Deer's Head State Hospital - Salisbury</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>3/5/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST PAULS CHURCHYARD</u>			
<b>23d. LOCATION (City, town or county)</b> <u>BERLIN</u>		<b>(State)</b> <u>MD</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anna A Burboze</u>			
<b>25a. REC'D BY REGISTRAR</b> <u>WAB</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hays</u>		<b>25c. DATE</b> <u>MAR 6 '62</u>			

MEDICAL CERTIFICATION

**THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER THE DEATH.**  
**THE FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Nov. 16, 1888

RECEIVED

CHAMBERLAIN

GEORGE DEWARO

No. 10-11-11

1/11/11

George Dewar  
1/11/11

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death and fill in pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03955

## CERTIFICATE OF DEATH

03951

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Nicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SAHSBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WHALEYVILLE</u> <u>23X-2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HORACE ANDREWS Smith</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 8 1962</u>					
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>NEGRO</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>7-27 1906</u>		<b>9. AGE</b> (In years and birthday) <u>55</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Motor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>W. Va.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>Thodore Smith</u>		<b>14. MOTHER'S M maiden NAME</b> <u>Helen Lloyd</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>382-09-4856</u>		<b>17. INFORMANT</b> <u>Anna Smith</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebroscerosis</u> 260X DUE TO (b) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u> <u>Indefinite</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>5 March 1962</u> <b>to</b> <u>8 March 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>8 March 1962</u> <b>and that death occurred at</b> <u>1:30 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>E. Russell</u>		<b>22b. DATE SIGNED</b> <u>10 March 62</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-12-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Outlets Chapel com</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Whaleyville</u>		<b>(State)</b> <u>MD</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Booker J. West</u>		<b>ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <u>10 March 62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Kline</u>		<b>DATE</b> <u>MAR 13 '62</u>					

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03952

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>38 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>417 High Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>James Andrew Smith</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>March 22 19 62</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 24, 1878</b>
<b>9. AGE</b> (In years last birthday) <b>83 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Kent Co. Maryland</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>James H. Smith</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah A. Atkinson</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>214-16-4184</b>		<b>17. INFORMANT</b> Address <b>Katie Smith - 417 High St. Chestertown Maryland</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> (b) <b>422</b> DUE TO Conditions, if any, which gave rise to immediate cause (c) <b>422</b> DUE TO (e), stating the underlying cause last.			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 yrs</b>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Fracture of left hip, intertrochanteric</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> <b>Chestertown</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Feb. 12, 1962</b> , <b>to</b> <b>March 22, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 22, 1962</b> , and that death occurred at <b>2:35 P.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Lee L. Lawry</b> M.D.		<b>22b. DATE SIGNED</b> <b>3/27/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Lee L. Lawry, M.D.</b>		<b>22d. ADDRESS</b> <b>Deer's Head Hospital; Salisbury, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>Mar. 24, 1962</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Chester Cemetery</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Chestertown, Md.</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. Williams</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>MAR 27 '62</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Thomas</b>

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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03953

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>		d. STREET ADDRESS <u>Route 1 Box 32</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Elizabeth</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 7, 1906</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Landing</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Coston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-01-8251</u>		17. INFORMANT <u>Robert Smith Westover, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Atherosclerosis</u> (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1962</u> to <u>March 16, 1962</u> that (I) (we) last saw the deceased alive on <u>March 15, 1962</u> and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Carrie Hearn</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CARRIE HEARN</u>				22d. ADDRESS <u>226 W. Chesapeake St. Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-18-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cottage Grove Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Westover, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Lange</u>				ADDRESS <u>New Church, Va.</u>		25a. REC'D BY REGISTRAR <u>  </u> DATE <u>MAR 22 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>			

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THE DEATH CERTIFICATE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Maryland  
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Mary E. Carter  
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03958

03954

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Wicomico</b></span>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Admit. 3-11-62</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>		d. STREET ADDRESS <b>Green Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pen Gen Hosp</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>CHARLES HENRY SMULLEN</b>				<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>26</b> Year <b>19 62</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Feb. 13, 18 88</b>			
<b>9. AGE</b> (In years last birthday) <b>74 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>13</b>		<b>IF UNDER 24 HRS.</b> Hours <b>1</b> Min. <b>13</b>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Worcester County, Md</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>			
<b>13. FATHER'S NAME</b> <b>Charles H. Smullen</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Clarrisa Jane Smullen</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Mr. Marion Rodney Smullen (Son)</b>		<b>17. INFORMANT</b> <b>Green St Fruitland, Maryland</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> (b) <b>Subacute cholecystitis</b> (c) <b>Cardiac moria (narrowed int. Coronary arteries)</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>585X</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>days</b> <b>weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Cerebral moria (narrowed int. Coronary arteries)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>3-12</u> 19<u>62</u> to <u>3-26</u> 19<u>62</u> that (I) (we) last saw the deceased alive on <u>3-26</u> 19<u>62</u>, and that death occurred <u>5:20 A.M.</u> from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>H. A. Briele</i>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>March 28 / 1962</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>H. A. Briele</b>				<b>22d. ADDRESS</b> <b>Medical Center-Salisbury, Maryland</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Mar. 28, 1962</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Smullen Family Cemetery (St Luke) R.D. # Salisbury, Md.</b>		<b>23d. LOCATION</b> (City, town or county) (State)			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>				<b>25a. REC'D BY REGISTRAR</b> <b>MAR 30 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Kline</i>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director may be retained by the hospital or attending physician. The funeral director: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03959

03955

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hebron</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.D.# 1</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hebron</u> d. STREET ADDRESS <u>R.D.# 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CARRIE MAE TAYLOR</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>MARCH 3rd 19 62</u>																	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 4, 1878</u>		<b>9. AGE</b> (In years last birthday) <u>83</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>11</u></td> <td><u>29</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>11</u>	<u>29</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<u>11</u>	<u>29</u>																				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mardela, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>													
<b>13. FATHER'S NAME</b> <u>Zackariah S. Phillips</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Elizabeth Kennerly</u>																	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Mr. John B. Taylor (Husband) R.D.#1 Hebron Md. &amp; Mrs. G. Walter Howard (Daughter)</u>																	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial thrombosis</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>severe Parkinson's disease &amp; sporadic paralysis</u> (c)								INTERVAL BETWEEN ONSET AND DEATH <u>4 days several years</u>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Severe Parkinson's disease &amp; sporadic paralysis</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>																	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>N/A</u> 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		<b>20f. (City or town)</b> <u>N/A</u>		<b>(County)</b> 		<b>(State)</b> 											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/2 1952</u> <b>to</b> <u>death</u> , 19 <u>62</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>mar 2 1962</u> , <b>and that death occurred at</b> <u>9:50 P.M.</u> <b>from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <u>Ernest M. Larmore</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>March 5/1962</u>													
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Ernest M. Larmore</u>						<b>22d. ADDRESS</b> <u>Delmar, Delaware</u>															
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>March 6, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Riverton Church Cemetery-</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Riverton, Maryland</u>															
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u>				<b>ADDRESS</b> <u>SALISBURY, MARYLAND</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 8 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>													

MEDICAL CERTIFICATION

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. THE FUNERAL DIRECTOR MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. THE FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN, THE FUNERAL DIRECTOR SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CAREFULLY. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

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CERTIFICATE OF DEATH

03960

03956

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>299 Bickford St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Tilghman</u> Last <u>Tilghman</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>I/18/1914</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory, Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U S A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>Wilson Tilghman</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Fallon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Norman Tilghman, Princess Anne, Md</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular</u> <u>442X</u> DUE TO <u>Hypertensive Cardiovascular Renal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Disease</u> (b) <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10 Mar</u> , 19 <u>62</u> to <u>12 Mar</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>12 Mar</u> , 19 <u>62</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>E. A. Funnell</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>  </u>		22d. ADDRESS <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/18/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		23d. LOCATION (City, town or county) (State) <u>Princess Anne, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Princess Anne, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 21 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

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SPITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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WEST-CALIF. DATE

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and the physician's name is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03961  
CERTIFICATE OF DEATH  
03957

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN b. <u>37 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Xiyaskin R.F.D.</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert A. Timmons</u>		4. DATE OF DEATH <u>MARCH 9 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>House Const.</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. FATHER'S NAME <u>George W. Timmons</u>		15. MOTHER'S MAIDEN NAME <u>Alice Nayward</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>219-14-4790</u>	
18. INFORMANT <u>Earl Williams, Xiyaskin, Md.</u>		19. ADDRESS <u>407 Camden Ave. Sal. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 162X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of Lung</u> (c) <u>20 years</u> DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>3-9</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3-9</u> , 19 <u>62</u> , and that death occurred at <u>1:30</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Earl L. Royer</u> M.D.		22b. DATE SIGNED <u>3-9-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl L. Royer</u>		22d. ADDRESS <u>407 Camden Ave. Sal. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/12/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Birchview Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Birchview, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Earl W. Roscoe, Birchview, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 12 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03962

03958

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>18 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> d. STREET ADDRESS <u>403 EAST STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>LLOYD RAYMOND TINGLE</u>		<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>22</u> Year <u>1962</u>		<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-18-1893</u>		<b>9. AGE</b> (In years last birthday) <u>69</u> rs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MEAT</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>DELMAR - MD</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>ELISHA TINGLE</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>VIOLETT FIGGS</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>						<b>16. SOCIAL SECURITY NO.</b> <u>214-10-6174</u>						<b>17. INFORMANT</b> <u>JERDIE TINGLE, DELMAR MD</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL METASTASIS</u> 1975 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>RHABDOMYOSARCOMA - BICEPS MUSCLE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4 Mar 1962</u> , <b>to</b> <u>22 Mar 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>22 Mar 1962</u> , <b>and that death occurred at</b> <u>12:15 PM</u> , <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Dr. Gray New</u> M.D.						<b>22b. DATE SIGNED</b> <u>22 Mar 62</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type)						<b>22d. ADDRESS</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>3-25-62</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MELSON</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>DELMAR - MD</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. S. Marshall Jr - Delmar, Del.</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 27 '62</u>						<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thorne</u>	

MEDICAL CERTIFICATION

The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be completed and filed with the State Department of Health within 72 hours after death. The law further requires that the death certificate be signed by the attending physician or by the funeral director. The law also requires that the death certificate be signed by the attending physician or by the funeral director. The law further requires that the death certificate be signed by the attending physician or by the funeral director.

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STATE OF MICHIGAN

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CERTIFICATE OF DEATH

03959

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD</u> <u>46 X-3</u> d. STREET ADDRESS <u>CLAYTON AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALLACE EDWARD TRUITT</u>				4. DATE OF DEATH Month Day Year <u>MARCH 15 1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-94</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM E. TRUITT</u>				14. MOTHER'S MAIDEN NAME <u>PARACONE HICKMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>221-18-9011</u>			
17. INFORMANT Address <u>ELIZABETH TRUITT FRANKFORD Del.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic and Acute Pyelonephritis</u> (c) <u>Sub-Deaphragmatic abscess with multiple abscesses</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>One year</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3 March 1962</u> to <u>15 March 1962</u> , that (I) (we) last saw the deceased alive on <u>15 Mar 1962</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>15 March</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-18-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CAREYS, Cem.</u>		23d. LOCATION (City, town or county) (State) <u>FRANKFORD, Del.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Watson &amp; Gray</u> ADDRESS <u>Frankford Del.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 20 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

MEDICAL CERTIFICATION

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SPIT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03964

03960

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>4 weeks</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		1939-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pleasant Care Nursing Home</b>		d. STREET ADDRESS <b>Maryland Ave.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>TULL</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1876</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		
11. BIRTHPLACE (State or foreign country) <b>Marion Station, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Robert Julius Tull</b>		14. MOTHER'S MAIDEN NAME <b>Mary Reddish</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Mrs. Eleanor Sterling--Maryland Ave.--Crisfield, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Degenerative Cardiovascular disease</b> 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized atherosclerosis</b> DUE TO (c) <b>?</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of prostate</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 23, 1962</b> to <b>March 17, 1962</b> that (I) (we) last saw the deceased alive on <b>March 11, 1962</b> and that death occurred at <b>2008</b> PM, from the causes and on the date stated above.				
22a. SIGNATURE <b>Robert T. Adkins</b>		22b. DATE SIGNED <b>MAR 20 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>Robert T. Adkins, M.D.</b>		22d. ADDRESS <b>Fruitland, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 20, 1962</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 '62</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03965

## CERTIFICATE OF DEATH

03961

1. PLACE OF DEATH e. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Shad Point</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D.# 1 (Allen Road)</b>				d. STREET ADDRESS <b>R.D.# 1 Salisbury, Maryland</b>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b> <b>WASHBURN</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>7th</b> Year <b>19 62</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1898</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (Employed at Ship Yard)</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Shad Point, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>Charles D. Washburn</b>			
14. MOTHER'S MAIDEN NAME <b>Mamie M. Fields</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>U. INFORMANT</b>				17. ADDRESS <b>Mrs. Alde E. Townsend (Sister) R.D.# 1 (Shad Point) Salisbury, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (e) <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Hour <b>N/A</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>B. Frank Giganti</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 8 / 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. B. Frank Giganti</b>				22d. ADDRESS <b>Medical Center-Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 10, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>R.D.# Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 12 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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USUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(11th Nov)

1945

(11th Nov)

11th Nov



SPIN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03966

## CERTIFICATE OF DEATH

03962

Items 8 & 9 Film G309 3/23/62 iwk

<b>1. PLACE OF DEATH</b> e. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRMOUNT</u> <u>19X-2</u> d. STREET ADDRESS <u>RURAL</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>CARRIE A WATERS</u>		<b>4. DATE OF DEATH</b> <u>MARCH 15 1962</u>					
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>COLORED</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10/12/1896</u>	<b>9. AGE</b> (In years last birthday) <u>65</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SEAFOOD</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>FAIRMOUNT MD.</u>			
<b>13. FATHER'S NAME</b> <u>EMERY O. WATERS</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARTHA WASHINGTON</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>146-18-7678</u>		<b>16. SOCIAL SECURITY NO.</b> <u>146-18-7678</u>		<b>17. INFORMANT</b> <u>ARMAN WATERS</u> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pyelonephritis</u> 260X } DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Diabetes Mellitus</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>1'</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19.....; that (I) (we) last saw the deceased alive on.....19....., and that death occurred at <u>11:57 AM</u>, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Walter S. Ellis, Jr.</u>		<b>22b. DATE SIGNED</b> <u>M.D.</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type)		<b>22d. ADDRESS</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>MAR. 18, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CETENHIAL</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anthony E. Ward Crispfield MD.</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 21 '62</u>			
<b>23d. LOCATION</b> (City, town or county) (State) <u>FAIRMOUNT MD.</u>							

SECRET

CONFIDENTIAL

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FOR STATE  
HEALTH DEPT.

THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY. IF DEATH IS NECESSARY, IT MAY BE EXECUTED AT ANY TIME. THE FUNERAL DIRECTOR, PAGE 1, 2, AND 3 MAY BE OBTAINED FOR YOUR FILES. THE FUNERAL DIRECTOR, PAGE 3, SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. FILE PAGES 1 AND 2 WITH THE STATE BOARD OF HEALTH, OR ITS DESIGNATED AGENT, PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

03967

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03963

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>15 Years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>		d. STREET ADDRESS <b>409 Camden Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>409 Camden Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Iris</b> Middle <b>tull</b> Last <b>White</b>				4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1883</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Alfred Tull</b>				14. MOTHER'S MAIDEN NAME <b>Stella Tull</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-7079</b>		17. INFORMANT Address <b>Miller White, Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crown Occlusion</b> <b>4-20.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Arterio Sclerotic Heart Disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b> <b>years</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>3-28-62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/29/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 30 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

THE STATE  
OF NEW YORK  
IN SENATE  
JANUARY 1, 1903

1898

REPORT OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF HEALTH  
FOR THE YEAR 1902

REPORT OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF HEALTH  
FOR THE YEAR 1902

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03964

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fruitland (Moore's Corner)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pen Gen. Hospital</b>		d. STREET ADDRESS <b>Box # 275</b>	
3. NAME OF DECEASED (Type or print) <b>SAMUEL GARDNER WILLEY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>7th</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1910</b>
9. AGE (In years last birthday) <b>51 yrs.</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>7</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Operator - Service Station</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eder, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel Q. Willey</b>		14. MOTHER'S MAIDEN NAME <b>Emma Washburn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Bernice B. Willey (Wife)</b>		18. ADDRESS <b>P.O. B. #275 Fruitland, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of liver &amp; hepatic coma</b> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hemorrhage from esophageal varices</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>
21. I certify that (I) (this hospital) attended the deceased from <b>7:15 A.M.</b> 19 <b>62</b> , to <b>March 7, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 7, 1962</b> , and that death occurred at <b>March 7, 1962</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William H. Fisher Jr.</b>		22b. DATE <b>March 7, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William H. Fisher Jr.</b>		22d. ADDRESS <b>Medical Center - Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 9, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Allen Church Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Allen, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>MAR 12 '62</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>	

MEDICAL CERTIFICATION

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1. The law requires that the death certificate be executed within 24 hours after the death. The law also requires that the death certificate be signed by the attending physician or the funeral director. The law also requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2. The law requires that the death certificate be signed by the attending physician or the funeral director. The law also requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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22. The law requires that the death certificate be signed by the attending physician or the funeral director. The law also requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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24. The law requires that the death certificate be signed by the attending physician or the funeral director. The law also requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

25. The law requires that the death certificate be signed by the attending physician or the funeral director. The law also requires that the death certificate be filed with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03969 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03965

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>		d. STREET ADDRESS <b>700 Westover Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>700 Westover Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles Williams</b>		First Middle Last		4. DATE OF DEATH Month <b>3</b> Day <b>20</b> Year <b>62</b>		9. AGE (In years last birthday) <b>About 50</b> yrs.	
5. SEX <b>M</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	10. AGE (In years last birthday) <b>About 50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chicken farming</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Williams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address <b>Sarah Wryk Suffolk Va. Gen. Dd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio-sclerotic cardio-vascular disease</b> Years (c) <b>80</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-21-62</b>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/30/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oberry</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury Md.</b>	
23. FUNERAL DIRECTOR <b>Alister F. Stewart</b>		ADDRESS <b>Salisbury Md.</b>		24a. REC'D BY REGISTRAR <b>APR 3 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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Unknown

*[Handwritten signature]*

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **Q3966**

FOR STATE  
HEALTH DEPT.

03970

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Tyaskin</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D.# 1 White Haven</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROSA</b> Middle <b>D.</b> Last <b>WILLING</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>22nd</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>July 21, 1886</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Accomac, County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>No Record</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INDEMNITY <b>Mr. W. W. Willing (Son) R.D.# 1 White Haven Tyaskin, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Coronary Occlusion</b> DUE TO <b>arterio Sclerotic / heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>N/A 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	20f. (City or town) <b>Rural</b>	(County) <b>Wicomico</b>	(State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>March 22 /1962</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 25/1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>				24a. REC'D BY REGISTRAR <b>APR 2 7 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason therefor in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

(M)

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause of death, and medical history. The form is partially filled out with handwritten text.

NAME: John J. Smith  
DATE: 10/15/1915  
TIME: 10:30 AM  
PLACE: Home  
CAUSE OF DEATH: Heart Disease  
MEDICAL HISTORY: None

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MEDICAL CERTIFICATION  
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15M 7/61

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MEDICAL CERTIFICATION  
1  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03971  
CERTIFICATE OF DEATH  
03967

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 3 Mos., 11 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rising Sun d. STREET ADDRESS Rural 07X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harris James Willis		4. DATE OF DEATH Month Day Year March 24 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2-1899
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill	
11. BIRTHPLACE (County & State, or foreign country) Essex County, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Willis		14. MOTHER'S MAIDEN NAME Lucy Pratt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-242904	
17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 456X DUE TO Gangrene of Lower extremities Endarteritis Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobular pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 mo. ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/13/61, 19, to 3/24/62, 19, that (I) (we) last saw the deceased alive on 3/24/62, 19, and that death occurred at 1:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman M.D.		22b. DATE 3-25-62	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22d. ADDRESS Deer's Head State Hospital - Salisbury	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-28-62	23c. NAME OF CEMETERY OR CREMATORY Mont. Zouar Cem.	23d. LOCATION (City, town or county) (State) Conowingo Md.
24. FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMillen		25a. REC'D BY REGISTRAR DATE MAR 27 '62	
ADDRESS Rising Sun Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b <u>257 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>1017 E. Church Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Wingate</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>25</u> Year <u>19 62</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov, 25, 1871</u>		<b>9. AGE</b> (In years last birthday) <u>90</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Weaving</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Asbury Smith</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Hillman</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>218-10-8679A</u>		<b>17. INFORMANT</b> <u>Mrs. Arianna W. Blizzard, Baltimore, Md.</u> Address <u>  </u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (a), stating the underlying cause last. (c) <u>  </u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)</b> <u>Carcinoma of left breast with metastasis</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>24 hours</u> <b>Years</b> <u>  </u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>  </u>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 11, 1961</u> , <b>to</b> <u>Mar. 25, 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 25, 1962</u> , <b>and that death occurred at</b> <u>9:25 P.M.</u> <b>from the causes and on the date stated above,</b>					
<b>22a. SIGNATURE</b> <u>L. V. Maldve, M. D.</u> <b>M.D.</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3/26/62</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>L. V. Maldve, M. D.</u>		<b>22d. ADDRESS</b> <u>Deer's Head Hospital; Salisbury, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/28/1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parsons Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Salisbury, Maryland</u> <b>(State)</b> <u>  </u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hill &amp; Johnson Co., Salisbury, Maryland</u> <b>ADDRESS</b> <u>  </u>					
<b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Cirilio L. Knaus</u>		<b>DATE</b> <u>MAR 29 '62</u>					

MEDICAL CERTIFICATION

TO SPECIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card for papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 7/61



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TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
03969										
1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN TB <b>286 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>924 S. Division St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Isaac Henry WYATT</b>			4. DATE OF DEATH Month <b>March</b> Day <b>26,</b> Year <b>19 62</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 24, 1868</b>		9. AGE (In years last birthday) <b>94</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Work</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Oriole, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				
13. FATHER'S NAME <b>William T. Wyatt</b>				14. MOTHER'S MAIDEN NAME <b>Alexine Hubbard</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Isaac H. Wyatt (Deceased)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June 13, 1961</b> , to <b>March 26, 1962</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1962</b> , and that death occurred at <b>6:20 P.M.</b> , from the causes and on the date stated above.										
22a. SIGNATURE <b>Lee L. Lawry</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>3/27/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M. D.</b>					22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 2, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>			23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>					ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>APR 2 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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